

**AETNA LIFE INSURANCE CO.
NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS**

CLAIMANT: READ THE FOLLOWING INSTRUCTIONS CAREFULLY

1. USE THIS FORM IF YOU BECOME SICK OR DISABLED **WHILE EMPLOYED** OR IF YOU BECOME SICK OR DISABLED **WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT**. USE **GREEN CLAIM FORM DB-300** IF YOU **BECOME SICK OR DISABLED AFTER HAVING BEEN UNEMPLOYED MORE THAN FOUR (4) WEEKS**.
2. YOU MUST COMPLETE ALL ITEMS OF PART A — THE "**CLAIMANT'S STATEMENT**". BE ACCURATE. CHECK ALL DATES.
3. BE SURE TO DATE AND SIGN YOUR CLAIM (SEE ITEM 12). IF YOU CANNOT SIGN THIS CLAIM FORM, YOUR REPRESENTATIVE MAY SIGN IT IN YOUR BEHALF. IN THAT EVENT, THE NAME, ADDRESS AND REPRESENTATIVE'S RELATIONSHIP TO YOU SHOULD BE NOTED UNDER THE SIGNATURE.
4. **DO NOT MAIL THIS CLAIM UNLESS YOUR HEALTH CARE PROVIDER COMPLETES AND SIGNS PART B — THE "HEALTH CARE PROVIDER'S STATEMENT"**.
5. YOUR COMPLETED CLAIM SHOULD BE MAILED **WITHIN THIRTY (30) DAYS AFTER YOU BECOME SICK OR DISABLED TO YOUR LAST EMPLOYER OR YOUR LAST EMPLOYER'S INSURANCE COMPANY**.
6. MAKE A COPY OF THIS COMPLETED FORM FOR YOUR RECORDS BEFORE YOU SUBMIT IT.

PART A — CLAIMANT'S STATEMENT (Please Print or Type) ANSWER ALL QUESTIONS

1. My name is _____
First Middle Last

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 Social Security Number
2. Address _____
Number Street City or Town State Zip Code Apt. No.
3. Tel. No. _____ 4. My age is _____ 5. Married (Check one) Yes No
6. My disability is (if injury, also state how, when, and where it occurred) _____
7. I became disabled on _____ a. I worked on that day Yes No
Month Day Year
- b. I have since worked for wages or profit. Yes No If "Yes", give dates _____
8. Give name of last employer. If more than one employer during the last eight (8) weeks, name all employers.

EMPLOYER'S			DATE OF EMPLOYMENT						AVERAGE WEEKLY WAGES
BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	FROM			THROUGH			(Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
			Mo.	Day	Yr.	Mo.	Day	Yr.	

9. My job is or was _____
Occupation Name of Union and Local Number, if Member
10. For the period of disability covered by this claim
 - a. Are you receiving wages, salary or separation pay: Yes No
 - b. Are you receiving or claiming:
 - (1) Workers' compensation for work-connected disability Yes No
 - (2) Unemployment Insurance Benefits Yes No
 - (3) Damages for personal injury Yes No
 - (4) Benefits under the Federal Social Security Act for long-term disability Yes No

IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 10a OR 10b, COMPLETE THE FOLLOWING:

I have received claimed from _____ for the period _____ to _____
Date Date
11. I have received disability benefits for another period or periods of disability within the 52 weeks immediately before my present disability began Yes No
 If "YES", fill in the following: I have been paid by _____ From _____ To _____
Date Date Date
12. I have read the instructions above. I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled; and that the foregoing statements, including any accompanying statements, are to the best of my knowledge true and complete.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

Claim signed on _____ Date _____ Claimant's Signature _____
 If signed by other than claimant, print below: name, address, and relationship of representative _____

IF YOU HAVE ANY QUESTIONS ABOUT CLAIMING DISABILITY BENEFITS, CONTACT THE NEAREST OFFICE OF THE NYS WORKERS' COMPENSATION BOARD, OR WRITE TO: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, NY 12241-0005.	SI TIENE DUDAS RELACIONADAS CON LA RECLAMACION DE BENEFICIOS POR INCAPACIDAD, COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA DE COMPENSACION OBRERA DE NUEVA YORK, O ESCRIBA A: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, NY 12241-0005.
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HEALTH CARE PROVIDER MUST COMPLETE PART B ON REVERSE

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

IMPORTANT: USE THIS FORM ONLY WHEN THE CLAIMANT BECOMES SICK OR DISABLED WHILE EMPLOYED OR BECOMES SICK OR DISABLED WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT. OTHERWISE USE GREEN CLAIM FORM DB-300.

PART B — HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type)

THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY AND THE FORM MAILED TO THE INSURANCE CARRIER OR SELF-INSURED EMPLOYER, OR RETURNED TO THE CLAIMANT WITHIN SEVEN DAYS OF THE RECEIPT OF THE FORM. For item 7d, give approximate date. Make some estimate. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date under "Remarks"

1. Claimant's Name _____ 2. Age _____ 3. Sex male female
 4. Diagnosis/Analysis _____ Diagnosis Code _____
 a. Claimant's Symptoms _____

b. Objective Findings _____

5. Claimant Hospitalized? Yes No From _____ To _____
 6. Operation Indicated? Yes No a. Type _____ b. Date _____

7. Enter Dates for the Following:

- a. Date of your first treatment for this disability
 b. Date of your most recent treatment for this disability
 c. Date claimant was unable to work because of this disability
 d. Date claimant will be able to perform usual work

Month	Day	Year

(Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined).

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease? Yes No
 If "Yes", has form C-4/C-48 been filed with the Workers' Compensation Board? Yes No

Remarks (attach additional sheet, if necessary) _____
 (If disability is pregnancy related, please enter estimated delivery date.)

I affirm that I am a	<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Physician	<input type="checkbox"/> Psychologist	Licensed in the State of	License Number
	<input type="checkbox"/> Dentist	<input type="checkbox"/> Podiatrist	<input type="checkbox"/> Nurse-Midwife		

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Health Care Provider's Signature _____ Date _____
 Health Care Provider's Name (Please Print) _____ Tel. No. _____
 Office Address _____
Number Street City or Town State Zip Code

EMPLOYER'S NOTICE OF CLAIM

EMPLOYER'S NAME _____ CONTROL NUMBER _____ SUFFIX _____ ACCOUNT _____
 EMPLOYER'S ADDRESS _____ SOC. SEC. NO. _____
 EMPLOYEE'S NAME AND ADDRESS _____

EMPLOYEE'S LEGAL ZIP CODE _____ PLEASE PROVIDE THE EMPLOYEE'S MAILING ADDRESS, INCLUDING ZIP CODE, USED WHILE RECEIVING DISABILITY BENEFITS. ALSO, ADVISE THE ZIP CODE OF THE EMPLOYEE'S LEGAL ADDRESS, IF DIFFERENT FROM THE MAILING ADDRESS. THIS ADDRESS WILL BE USED TO DETERMINE STATE AND LOCAL TAX AUTHORITIES.

IF CLAIMANT SUBJECT TO FICA WITHHOLDING, ENTER FICA CODE (SEE CODES BELOW)

PERCENTAGE OF EMPLOYEE CONTRIBUTION TOWARD DISABILITY PREMIUM _____ %. (IF NONE SHOWN WE WILL ASSUME EMPLOYER PAYS ALL).

DATE OF EMPLOYMENT _____ DATE OF BIRTH _____ FULL TIME WORKER PART TIME WORKER

EMPLOYER'S FEDERAL IDENTIFICATION NO. _____ S M T W Y F S
 IF NORMAL WORK WEEK OTHER THAN 5 DAYS CHECK APPROPRIATE BOXES TO SHOW DAYS WORKED

AVERAGE WEEKLY EARNINGS FOR THE 8 WEEKS IMMEDIATELY PRECEDING LAST DAY WORKED \$ _____

AVERAGE WEEKLY EARNINGS FOR 8 PAYROLL WEEKS IMMEDIATELY PRECEDING LAST DAY WORKED EXCLUDING THE PAYROLL WEEK IN WHICH DISABILITY BEGAN (i.e., 7 FULL PAYROLL WEEKS) \$ _____

TO COMPUTE THE AVERAGE WEEKLY WAGE divide the total remuneration (including, board, lodging, gratuities, etc.), paid by you to your employee during the eight (8) weeks immediately preceding and including his last day worked prior to the commencement of disability, by the number of weeks during which he/she worked on at least one day during such eight (8) week period.

DATE LAST WORKED _____ WAS MORE THAN A HALF DAY WORKED ? YES NO

DATE & HOUR DISABILITY BEGAN _____ AM PM DATE & HOUR RETURNED TO WORK _____ AM PM

IF FULL WAGES OR OTHER BENEFITS ARE PAID DURING DISABILITY INDICATE AMOUNT PER WEEK \$ _____ WAGES SICK PAY VACATION
 NUMBER WEEKS _____ AND WHETHER EMPLOYER REQUESTS REIMBURSEMENT (ALLOWED ONLY IF WAGES OR SICK PAY PROVIDED)? YES NO
 ESTIMATED DATE SALARY CONTINUANCE WILL CEASE _____

IS ILLNESS OR INJURY DUE TO OCCUPATIONAL CAUSES? YES NO IF YES, PLEASE PROVIDE COPY OF C-7 NOTICE OF CONTROVERSY.

REMARKS _____

SIGNED _____ DATE _____
(EMPLOYER'S REPRESENTATIVE) (TITLE) (TELEPHONE NUMBER)

FICA CODE

Enter a two digit numeric code to indicate whether or not the claimant is subject to FICA. The codes (with explanations) are:

- | | | |
|--|--|--|
| 01 - Yes, subject to FICA tax, <i>but actual deduction, if any, based on employer's contribution to premium.</i> | 04 - No, FICA tax not withheld since the employee is not a participant in the FICA program (e.g., city, state, Federal). | 05 - No, FICA tax not withheld since the employee is on salary continuance and employer is withholding FICA. |
| 06 - No, FICA tax not withheld since the employee is owner/proprietor (i.e., self-employed). | 07 - No, FICA tax not withheld since the FICA maximum contribution/earnings base has been exceeded. | 08 - No, FICA tax not withheld. Due to special alien status, employee is not subject to FICA. |