The Business Council INSURANCE FUND

Aetna DBL Claim Forms should be mailed to:

Aetna Life Insurance Company
Short Term Disability Claims
PO Box 14560
Lexington, Kentucky 40512-4560

Fax: (866) 667-1987
Phone: (866) 326-1380

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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 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) ☐☐☐ ☐☐ ☐☐☐☐ Social Security Number
2. Address _____ (Number / Street / City or Town / State / Zip Code / Apt. No.)
3. Tel. No. _____ 4. Date of Birth _____ 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 _____ (Month / Day / Year) a. I worked on that day ☐ Yes ☐ No
   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 (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	FROM			THROUGH			
			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 _____ (Date) to _____ (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 _____ (Date) To _____ (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

_____

Disclosure of Information: The Board will not disclose any information about your case to any unauthorized party without your consent. If you choose to have such information disclosed to an unauthorized party, you must file with the Board an original signed Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records, or an original signed, notarized authorization letter. You may telephone your local WCB office to have Form OC-110A sent to you, or you may download it from our web page, www.wcb.state.ny.us. It can be found under the heading Common Forms Online. Mail the completed authorization form or letter to the address given below.

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.

HEALTH CARE PROVIDER MUST COMPLETE PART B ON REVERSE

WKAB-ME

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 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. Date of Birth _____ 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:

	Month	Day	Year
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			

(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 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	Licensed in the State of	License Number
☐ Chiropractor ☐ Physician ☐ Psychologist ☐ Dentist ☐ Podiatrist ☐ 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

HIPAA NOTICE – In order to adjudicate a workers'compensation claim, WCL 13-a(4)(a) and 12 NYCRR 325-1.3 requrie health care providers to regularly file medical reports of treatment with the Board and the carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

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. _____
IF NORMAL WORK WEEK OTHER THAN 5 DAYS CHECK APPROPRIATE BOXES TO SHOW DAYS WORKED S ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ S ☐
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)**

Mail this completed form to: Aetna Life Insurance Company, P.O. Box 14560, Lexington, KY 40512-4560, **Phone:** 866-326-1380, **Fax:** 866-667-1987

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, *but actual deduction, if any, based on employer's contribution to premium.*
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.