# SHORT-TERM DISABILITY (STD) FORM
# TWU L100 & ATU L726/L1056

HR-BEN-753

| SECTION 1 – EMPLOYEE INFORMATION | | | | |
|---|---|---|---|---|
| Print Name *(NAZWISKO, IMIE - TY WYPELNIASZ / last, first name)* | Last First M.I. Suffix | | BSC ID *(TY)* | Pass Number |
| Job Title Light Maintainer | Department MOW - Infrastructure | | Union TWU Local 100 *(TY)* | |
| Phone (H) *(TY)* | Phone (W) *(TY)* | | Email *(TY)* | |

| Section 2– TO BE COMPLETED BY PENSION BENEFITS DESIGNATED OFFICIAL (OFFICE USE ONLY) | | |
|---|---|---|
| ☐ Approved ☐ Disapproved *(NIE TY - Sekcja 2 wypelnia MTA / NOT YOU - Section 2 is MTA office use only)* | | |
| If disapproved: ☐ Untimely ☐ Incomplete ☐ Other (Explain) | | |
| If approved, complete the following:<br>MTA Consolidated Pensions has reviewed the attached Short-Term Disability (STD) form DB-450 or DB-300 if applicable for employees terminated within four weeks of employment, and the Divisional/Depot Pre-Application. The employee noted above may be eligible for STD benefits equivalent to 50% of average weekly wages (over the last eight weeks) up to a maximum of $170 per week, subject to New York State Disability law. The disability period covered by this authorization will not exceed a total of 26 weeks from the date of disability or 26 weeks in a 52-week period.<br>This employee, if eligible, may be issued a STD check for the disability, subject to a seven-day waiting period (where applicable), for a continuous disability not before the following day and date_____. | | |
| Print Name | Title | Pass No. |
| *(NIE TY - wypelnia MTA / NOT YOU - MTA fills this)* Signature | Date | |

NYSIF
New York State Insurance Fund

# NEW YORK STATE
# NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

Please read instructions on page 2 carefully to avoid a delay in processing. You must answer all questions in Part A and questions 1 through 4 in Part B. Health care providers must complete Part B on page 2. Your employer should complete part C. However, do not delay submitting the form to NYSIF if you have difficulty getting part C completed.

## PART A – CLAIMANT'S INFORMATION (Please Print or Type)

1. First Name:_____ MI:_____ Last Name:_____
2. Mailing Address:_____
   Number Street Apartment # City or Town State Zip Code
3. Daytime Phone #: _____ E-mail Address: _____
4. Social Security #: _____ 5. Date of Birth: _____ 6. Gender: ◯ Male ◯ Female ◯ Other
7. Describe your disability (if injury, also state how, when and where it occurred): _____
   _____
8. Date you became disabled: _____ Did you work on that day? ◯ Yes ◯ No
   Have you recovered from this disability? ◯ Yes ◯ No If Yes, date you were able to return to work: _____
   Have you since worked for wages or profit? ◯ Yes ◯ No If Yes, list dates: _____
9. Name of last employer prior to disability. If more than one employer in previous eight (8) weeks, name all employers. Average Weekly Wage is based on all wages earned in last eight (8) weeks worked.

| LAST EMPLOYER PRIOR TO DISABILITY | | | PERIOD OF EMPLOYMENT | | **Average Weekly Wage** (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.) |
|---|---|---|---|---|---|
| Firm or Trade Name | Address | Phone Number | First Day | Last Day Worked | |
| | | | Mo. Day Yr. | Mo. Day Yr. | |
| **OTHER EMPLOYER during last eight (8) weeks** | | | **PERIOD OF EMPLOYMENT** | | **Average Weekly Wage** (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.) |
| Firm or Trade Name | Address | Phone Number | First Day | Last Day Worked | |
| | | | Mo. Day Yr. | Mo. Day Yr. | |
| | | | Mo. Day Yr. | Mo. Day Yr. | |

10. My job is or was: _____ 11. Union Member: ◯ Yes ◯ No If Yes, _____
    Occupation Name of Union or Local Number
12. Were you claiming or receiving Unemployment prior to this disability? ..... ◯ Yes ◯ No
    If you did **not** claim or if you claimed but did not receive unemployment insurance benefits after LAST DAY WORKED, explain reasons fully: _____
    If you did receive unemployment benefits, provide all periods collected: _____
13. 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. Paid Family Leave ..... ◯ Yes ◯ No
       3. Unemployment Insurance Benefits ..... ◯ Yes ◯ No
       4. No-Fault motor vehicle accident ..... ◯ Yes ◯ No
          or personal injury involving a third party? ..... ◯ Yes ◯ No
       5. Long-term disability benefits under the Federal Social Security Act for *this* disability? ..... ◯ Yes ◯ No

**IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 13, COMPLETE THE FOLLOWING:**

I have: ☐ received ☐ claimed from: _____ for the period _____ to _____

14. In the 52 weeks before your disability began, have you received disability benefits for other periods of disability? ... ◯ Yes ◯ No
15. In the 52 weeks before your disability began, have you received Paid Family Leave? ..... ◯ Yes ◯ No
16. If you became disabled while employed or within four weeks of your last day worked, did your employer provide you with your rights under Disability Law within 5 days of your notice or request for disability forms? ..... ◯ Yes ◯ No

I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled. I have read the instructions on page 2 of this form and that the foregoing statements, including any accompanying statements are, to the best of my knowledge, true and complete.

_____ _____
Claimant's signature Date

An individual may sign on behalf of the claimant only if they are legally authorized to do so and the claimant is a minor, mentally incompetent or incapacitated. If signed by other than claimant, print info below, complete & submit Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records.

_____ _____ _____
On behalf of claimant Address Relationship to Claimant

## PART B – HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type) NYSIF

**THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY. THE ATTENDING HEALTH CARE PROVIDER SHALL COMPLETE AND RETURN TO THE CLAIMANT WITHIN SEVEN (7) DAYS OF RECEIPT OF THIS FORM**. For item 7-d, you must give estimated date. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date in item 7-e. **INCOMPLETE ANSWERS MAY DELAY PAYMENT OF BENEFITS**.

1. First Name: _____ MI: ____ Last Name: _____
2. Gender: ◯ Male ◯ Female ◯ Other 3. Date of Birth: _____ 4. Phone #: _____
5. Diagnosis/Analysis: _____ Diagnosis Code: _____
   a. Claimant's symptoms: _____
   _____
   b. Objective findings: _____
   _____
6. Claimant hospitalized? ☐ Yes ☐ No From: _____ To: _____
7. Operation indicated? ☐ Yes ☐ No a. Type: _____ b. Date: _____

| 8. 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 again be able to perform work (Even if considerable question exists, estimate date. Avoid the use of terms such as unknown or undetermined.) | | | |
| e. If pregnancy-related, please check box and enter the date ☐ estimated delivery date OR ☐ actual delivery date | | | |

9. 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 Board? ☐ Yes ☐ No

I certify that I am a:

_____ _____ _____
(Physician, Chiropractor, Dentist, Podiatrist, Psychologist, Nurse-Midwife) Licensed or Certified in the State of License Number

_____ _____ _____
Health Care Provider's Printed Name Health Care Provider's Signature Date

_____ _____ _____
Health Care Provider's Address Phone Number Fax Number

**IMPORTANT NOTICE TO CLAIMANT- READ THESE INSTRUCTIONS CAREFULLY**

**PLEASE NOTE: Do not date and file this form prior to your first date of disability. In order for your claim to be processed, Parts A and B must be completed.**

1. If you are using this form because you became disabled while employed or you became disabled within four (4) weeks after termination of employment, your completed claim should be mailed within thirty (30) days to your employer or your last employer's insurance carrier. You may find your employer's disability insurance carrier on the Workers' Compensation Board's website, wcb.ny.gov, using Employer Coverage Search.
2. If you are using this form because you became disabled after having been unemployed for more than four (4) weeks, your completed claim must be mailed to: Workers' Compensation Board, Disability Benefits Bureau, PO Box 9029, Endicott, NY 13761-9029. If you answered "Yes" to question 13.B.1, please complete and attach Form DB-450.1.

If you do not receive a response within 45 days or if you have questions about your disability benefits claim, please call your employer's insurance carrier. For general information about disability benefits, please visit wcb.ny.gov or call the Board's Disability Benefits Bureau at (877) 632-4996.

**Notification Pursuant to New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and Federal Privacy Act of 1974 (5 USC § 552a)**
The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

**HIPAA NOTICE** - In order to adjudicate a workers' compensation claim or disability benefits claim, WCL 13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the insurance 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.

**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". This form is available on the WCB website (wcb.ny.gov) and can be accessed by clicking the "Forms" link. If you do not have access to the internet please call (877) 632-4996 or visit our nearest Customer Service Center to obtain a copy of the form. In lieu of Form OC-110A, you may also submit an original signed, notarized authorization letter.

An employer or insurer, or any employee, agent, or person acting on behalf of an employer or insurer, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.