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FIRST RELIANCE STANDARD
Life Insurance Company

New York Disability Benefit Law
Short Term Disability Benefits
Initial Statement of Claim

HOW TO FILE A CLAIM

Please follow the instructions listed below to avoid unnecessary delays in processing your claim. This form must be fully completed for each disability claim. If the claim form is not fully completed, the processing of the claim may be delayed.

Employee 1) Complete and sign Part I answering all questions; and
2) Complete and sign the AUTHORIZATION FOR USE IN OBTAINING INFORMATION form; and
3) Have your medical provider complete and sign the MEDICAL PROVIDER STATEMENT (Part III).

Employer 1) Complete and sign Part II answering all questions.

When all sections of this form have been completed submit the claim to: **Reliance Standard Life Insurance Company**
P.O. Box 7749
Philadelphia, PA 19101-7749
(800) 351-7500 or
You May Fax to: (267) 256-3519

PART I **FOR EMPLOYEE TO COMPLETE**

Employee's Name Last First Middle Initial	Employee's Birth Date	Employee's Social Security No.	Sex ☐ Male ☐ Female

Employee's Address (Street, City, State, Zip)	Employee's Occupation

Is this claim based on an accident? ☐ Yes ☐ No	Did injury occur at work? If "Yes," for whom were you working? ☐ Yes ☐ No

Last day worked	Did you work a full day? ☐ Yes ☐ No	Date you were first unable to work because of this disability

Date of Accident	Time ☐ AM ☐ PM	How and where did accident happen?

Give name of last employer. If more than one employer during the last eight (8) weeks, name all employers.

EMPLOYERS			DATES OF EMPLOYMENT		AVERAGE WEEKLY WAGES (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	FROM Mo. Day	THROUGH Mo. Day Yr.	
FF Thompson Hosp.	Policy 251959/670401	585-396-6680			

Are you now receiving or eligible to receive as a result of this disability:
Social Security ☐ Yes ☐ No
Worker's Compensation ☐ Yes ☐ No
State Disability ☒ Yes ☐ No
No Fault Disability ☐ Yes ☐ No
Other _____ ☐ Yes ☐ No
If "Yes" give name and address of insurer, amount of income, date benefits began and ended.

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)

Name and Address of Medical Provider	Date you returned to work	Are you now receiving Unemployment Compensation benefits? ☐ Yes ☐ No

Any person who knowingly and with intent to injure First Reliance Standard Life Insurance Company files a statement of claim or submits any information in conjunction with a claim containing fraudulent, false, misleading, incomplete or deceptive information commits a fraudulent insurance act, which is a crime. These actions will result in the denial of the claim, and are subject to prosecution under state and/or federal law. First Reliance Standard Life Insurance Company will pursue any and all appropriate legal remedies arising from such fraudulent insurance acts.

Employee's Signature	Telephone Number ( )	Date

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 DUDAD REPLACIONADAS 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

FIRST RELIANCE STANDARD
Life Insurance Company

AUTHORIZATION FOR USE IN OBTAINING INFORMATION

NAME OF INSURED: _____
INSURED'S SSN: _____
POLICYHOLDER: FF Thompson Hospital Policy 251959/670401

To all physicians and other health care professionals, hospitals, other health care institutions, insurers, medical, hospital and prepaid health plans, pharmacies, employers, group policyholders, contract holders, governmental agencies (including but not limited to the Social Security Administration), private and/or public benefit plan administrators, and/or attorney representatives, including but not limited to covered entities and business associates under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the accompanying regulations:

You are authorized to provide First Reliance Standard Life Insurance Company and/or its authorized administrators with information concerning medical care, advice, and/ or treatment provided to me, the above named Insured, and/or any employment, salary and/or benefit -related information concerning me, the above named Insured. I understand that the disclosure of information may include disclosure of protected health information under HIPAA and the accompanying regulations, information regarding treatment for mental illness, the human immunodeficiency virus (HIV) and/or the use of drugs and alcohol. I also understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be subject to protection under HIPAA and the accompanying regulations. A statement of First Reliance Standard Life Insurance Company's privacy policy is available at www.frsli.com or upon request.

I understand that any such information will be used for the purpose of evaluating my claim for benefits. Upon request, I understand that I am entitled to receive a copy of this Authorization. This Authorization is valid from the date signed for the duration of the claim, and may be revoked by me at any time upon written request to the address below. A reproduction of this Authorization shall be considered as valid as the original.

_____ _____
Date Insured's Signature

(If the Insured is unable to sign, an authorized person may sign.)

_____ _____
Date Authorized Person's Signature

Description of Authorized Person's authority to sign on behalf of Insured:

_____

PART II	**FOR EMPLOYER TO COMPLETE**			
Employee's Name	Social Security No.	STD Policy No. 670401 DBL Policy No. NYS dbl 251959		
Job Title	Insurance Class	Hire Date	Date Enrollment Card Signed	Effective Date of Insurance
Date Laid Off (If Applicable)	Date Retired (If Applicable)	Weekly Earnings	Date Last Worked	Date Returned to Work
Is Employee receiving sick leave benefits from present employer? ☐ Yes ☐ No	Date Began	Dated Ended	Reason For Stopping Work	
Is Disability Due To Employment? ☐ Yes If yes, explain ☐ No	Brief Description of Duties			

Date Employee wages ceased.	
Date Employee returned to work.	
Has Employment terminated?	☐ Yes ☐ No
If so, date of termination.	
Was Employee laid off or was layoff contemplated prior to disability?	
If so, give day of layoff.	
Are wages geing continued during disability?	☐ Yes ☐ No
If so, does your Employer request reimbursement.	☐ Yes ☐ No
Was Employee on the job when disability occurred?	☐ Yes ☐ No
Has claim been filed for Workmen's Compensation	☐ Yes ☐ No
If yes, WC carrier name and address	
Is Employee member of a union that provides payment of weekly cash benefits?	☐ Yes ☐ No
If yes, give name and address of union.	

Is this claimant a N.Y. employee? ☐ Yes ☐ No ☐ Full Time ☐ Part Time
Normal work week (check boxes to show usual days worked)

S	M	T	W	TH	F	S
☐	☐	☐	☐	☐	☐	☐

Gross Earnings 8 weeks prior to disability					
Week Ending	No. Days				
	Mo.	Day	Yr.	Worked	Gross Amount
1					
2					
3					
4					
5					
6					
7					
8					

Contribution % paid by Employee – post tax. 100
Contribution % paid by Employee 17%

Employer Name & Address	FF Thompson Hospital 350 Parrish Street	Associate Services Canandaigua, NY 14424	Employer's Telephone Number 585-396-6681
Authorized Signature	Date	Title Benefits Administrator	Fax Number and Email Address johnpaul.mlynar@thompsonhealth.com 585-396-6480

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 FORM DB-300.

PART III MEDICAL PROVIDER'S STATEMENT (PLEASE ANSWER ALL QUESTIONS AND SIGN)

Patients Name

Diagnosis and Concurrent Conditions

Surgical or Obstetrical Procedure

Current Medications

Frequency of Treatment ☐ Weekly ☐ Other ☐ Monthly

Is condition due to injury or sickness arising from patient's employment? ☐ Yes ☐ No	Has patient ever had same or similar symptoms? ☐ Yes ☐ No If Yes, when	
Date symptoms first appeared or accident happened	Date patient first consulted you for this condition	Is patient still under your care for this condition? ☐ Yes ☐ No
If condition is due to pregnancy, give LMP and expected date of delivery. LMP _____ Expected Date of delivery _____	If patient hospitalized, give name of hospital Admission Date _____ Discharge Date _____	
Is patient able to perform his/her job? ☐ Yes ☐ No	Date patient was continuously unable to work From _____ To _____	
Estimate date patient should be able to return to work.	Patient will be partially disabled From: To:	

MENTAL CONDITION

Is the patient competent to endorse checks and direct the use of the proceeds thereof? ☐ Yes ☐ No

COMPLETE THIS SECTION ONLY IF DISABILITY IS DUE TO CARDIAC CONDITION

CARDIAC

Functional Capacity (American Heart Ass'n) ☐ Class 1 (no limitation) ☐ Class 2 (slight limitation) ☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)

Blood Pressure and Dates

COMPLETE THIS SECTION ONLY IF DISABILITY IS DUE TO VISUAL IMPAIRMENT

VISUAL IMPAIRMENT

		Snellen Notation				
What was vision at last observation?	With Glasses	O.D.	O.S.	Month	Day	20
	Without Glasses	O.D.	O.S.	Month	Day	20

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I affirm that I am a ☐ Chiropractor ☐ Physician ☐ Psychologist ☐ Dentist ☐ Podiatrist ☐ Nurse-Midwife	Licensed in the State of	License Number

Medical Provider's Name, Address, ZIP (Please Print or Type)

Telephone Number ( )	Fax Number ( )	Specialty
Medical Provider's Signature Date	Degree	Medical Provider's Tax ID No.

IMPORTANT: PLEASE ATTACH ALL MEDICAL RECORDS FROM THREE (3) MONTHS PRIOR TO DATE OF DISABILITY TO PRESENT.

HIPAA NOTICE – In order to adjudicate a worker's compensation claims, WCL-13-1(4)(a) and 2 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatments 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.