New York City District Council of Carpenters
BENEFIT FUNDS

395 Hudson Street
New York, NY 10014
Telephone: (212) 366-7300

Dear Participant:

Enclosed please find an application for Short-Term Disability ("STD") benefits. This benefit is administered by the New York City District Council of Carpenters Welfare Fund (the "Welfare Fund"). Please complete, sign, and answer **ALL** questions on **Part A** of the form. **Part B** is to be completed and signed by your attending physician. **Part C** is to be completed and signed by a representative of the city agency by which you are employed.

****Part C - If Question # 6 is answered "YES" a memo on company letterhead indicating the date payments will cease will be required from a representative of the city agency by which you are employed.**

The Welfare Fund requires STD benefits to be directly deposited to your banking account. Please sign and provide your banking information on the enclosed Direct Deposit form. Once your application has been approved for payment, **your first payment will be mailed directly to you in check format and the following payments will be deposited directly** into the bank account you provided on the enclosed form.

Please submit all completed documents together, along with the signed Direct Deposit form, to the Welfare Fund. You may mail it to the attention of the Welfare Fund at 395 Hudson Street, New York, NY 10014 or fax it to (212) 366-3301. Upon receipt of your application, we will determine your eligibility for these benefits and process payment if eligible.

Benefits are payable as long as you remain disabled, up to a maximum of 26 weeks of disability in any 52-week period. Please note, if you return to work prior to the date indicated by your physician, you are required to contact the Welfare Fund office immediately to stop your STD benefits. You will be responsible to pay back the Fund any STD benefits received during the time wages were reported by your employer.

In the event your disability continues beyond an initial 26-week period and have more than 5 vesting credits towards your pension, you may be entitled to a disability benefit from the NYCDCC Pension Fund. You may contact the Welfare Fund to initiate your pension application.

For more information concerning Welfare and Pension benefits, please visit our website, www.nyccbf.com. If you have any questions, please contact the Welfare Fund at (800) 529-3863 and we will be happy to assist you.

Sincerely,

NYCDCC Welfare Fund

New York State

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

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

1. Last Name: _____ First Name: _____ MI: ___

2. Mailing Address (Street & Apt. #): _____

City: _____ State: _____ Zip: _____

3. Daytime Phone #: _____ Email Address: _____

4. Social Security #: _____ - _____ - _____ 5. Date of Birth: ___ / ___ / _____ 6. Gender: ☐ M ☐ F ☐ X

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(S) PRIOR TO DISABILITY			PERIOD OF EMPLOYMENT		
Firm or Trade Name	**Address**	**Phone Number**	**First Day** (MM/DD/YYYY)	**Last Day Worked** (MM/DD/YYYY)	**Average Weekly Wage** (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)

Enter total wages earned in the last 8 weeks prior to the first day of disability below (Include wages for all employers listed above)

Week No.	Last Day Worked (MM/DD/YYYY)	No. of Days Worked	Gross Amount Paid
1			$0.00
2			$0.00
3			$0.00
4			$0.00
5			$0.00
6			$0.00
7			$0.00
8			$0.00
		Calculated average gross weekly wage:	$0.00

10. My job is or was: _____ (Occupation) 11. Union Member: ☐ Yes ☐ No If "Yes": _____ (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: _____

_____

DB-450 10-23

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

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. Unemployment Benefits? ☐ Yes ☐ No 2. Paid Family Leave? ☐ Yes ☐ No
    3. Workers' compensation for work-connected disability? ☐ Yes ☐ No
    4. No-Fault motor vehicle accident? ☐ Yes ☐ No **or** personal injury involving 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 year (52 weeks) before your disability began, have you received disability benefits for other periods of disability? ☐ Yes ☐ No
    If yes, Paid by: _____ from: ____ / ____ / _____ to: ____ / ____ / _____
15. In the year (52 weeks) before your disability began, have you received Paid Family Leave? ☐ Yes ☐ No
    If yes, Paid by: _____ from: ____ / ____ / _____ to: ____ / ____ / _____
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

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I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled. I have read the instructions of this form and certify 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 information below and complete and 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)

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. 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. Last Name: _____ First Name: _____ MI: __
2. Gender: ☐ M ☐ F ☐ X 3. Date of Birth: ___ / ___ / _____
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 again be able to perform work (Even if considerable question exists, estimate date. Avoid 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			

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 medical been filed with the Board? ☐ Yes ☐ No

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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 #**

PART C - EMPLOYER INFORMATION (to be completed by the employer)

1. Business's full legal name and mailing address

Business Name _____

Mailing Address _____

City, State _____

Zip Code _____

Country (if not U.S.A.) _____

2. Employer's FEIN: _____

3. Contact Information:

Employer's contact name for questions relating to disability: _____

Employer's contact telephone number: _____

Employer's contact email address: _____

4. Is the employee a member of a union that provides the statutory disability benefits? ☐ Yes ☐ No

*If yes, provide Union name, address, and contact information _____

_____

5. Employee Information:

Employee's role: ☐ Employee ☐ Proprietor ☐ Partner ☐ Spouse of Employer ☐ Owner ☐ Co-Owner

Employee's date of hire (MM/DD/YYYY): _____

Date employee last worked: _____

Date employee returned to work (if applicable): _____

6. Were wages continued during disability? ☐ Yes ☐ No

If yes, what type? (PTO, sick time, other): _____

If yes, is reimbursement requested by employer? ☐ Yes ☐ No

*Reimbursement is only available if employer continued salary during disability or employee used sick time

7. Is the employee's disability work-related? ☐ Yes ☐ No

8. Enter the last 8 weeks of gross wages for the employee immediately prior to the disability starting with the week the disability began, and calculate the average gross weekly wage (include bonuses, tips, commissions, reasonable value of board, rent, etc. and see instructions for more information)

Week No.	Week ending date (MM/DD/YYYY)	No. of days worked	Gross amount paid
1			$0.00
2			$0.00
3			$0.00
4			$0.00
5			$0.00
6			$0.00
7			$0.00
8			$0.00
		Calculated average gross weekly wage:	$0.00

9. In the preceding 52 weeks has the employee taken leave for:

☐ NYS Disability ☐ PFL ☐ Both Disability and PFL ☐ None

Disability: Please provide specific dates for disability _____

PFL: Please provide specific dates for PFL _____

10. Is employee still in your employment? ☐ Yes ☐ No

If no, date employment was terminated: _____

11. If employee received unemployment benefits, date the benefit was last received: _____

PART C - EMPLOYER INFORMATION (to be completed by the employer)

I have read and acknowledge the fraud information below and affirm that to the best of my knowledge and belief, the information I have provided is true and accurate.

Employer Name and Title: _____

Employer Signature: _____

Employer Contact Phone Number: _____

Date: _____

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 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 "Claimants Authorization to Disclose Workers' Compensation Records." This form is available on the WCB website (**www.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. In lieu of Form OC-110A, you may also submit an original signed, notarized authorization letter.

FRAUD ACKNOWLEDGEMENT - 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.

New York City District Council of Carpenters Welfare Fund
Authorization Form for Release of Medical Information

I _____ hereby authorize the use or disclosure of my health information as described in this authorization.

1. Specific person/organization *(or class of persons)* authorized to provide the information:

   New York City District Council of Carpenters Welfare Fund

2. Specific person/organization *(or class of persons)* authorized to receive all of the below information:

   ☐ _____

3. Specific and meaningful description of the information:

   Please check the applicable box or describe the information you wish the Fund to disclose:

   ☐ Copy of Birth Certificate ☐ Copy of Marriage Certificate

   ☐ Written, electronic and oral information related to eligibility for benefits for the time period commencing on _____ and continuing through _____.

   ☐ Written, electronic and oral information including claims, reports, and other documents related to claims for benefits for an injury or illness commencing on _____ and continuing through _____

   ☐ Other: _____

4. ***Purpose of the request:*** Please state the purpose of the request below. If you do not wish to state a purpose, please state, "At the request of the individual." The Fund will forward authorization to the appropriate parties. _____

5. ***Right to Revoke:*** I understand that I have the right to revoke this authorization at any time by notifying New York City District Council of Carpenters Welfare Fund in writing at 395 Hudson Street, New York, NY 10014. I understand that the revocation is only effective after it is received and logged by the Fund. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

6. I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it again.

7. I understand that I am entitled to receive a copy of this authorization.

8. I understand that this authorization will **expire within one year** of the date of this authorization is signed.

9. The Fund will not condition treatment, payment, enrollment or eligibility for health plan benefits on receipt of an authorization.

_____ _____

Signature of Individual Date

_____

Address

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign the form on the basis of:

This authorization reflects the requirements of 45 C.F.R. § 164.508 (August 14, 2002, as updated by HITECH, January 25, 2013)

New York City District Council of Carpenters
BENEFIT FUNDS

395 Hudson Street
New York, NY 10014
Telephone: (212) 366-7300

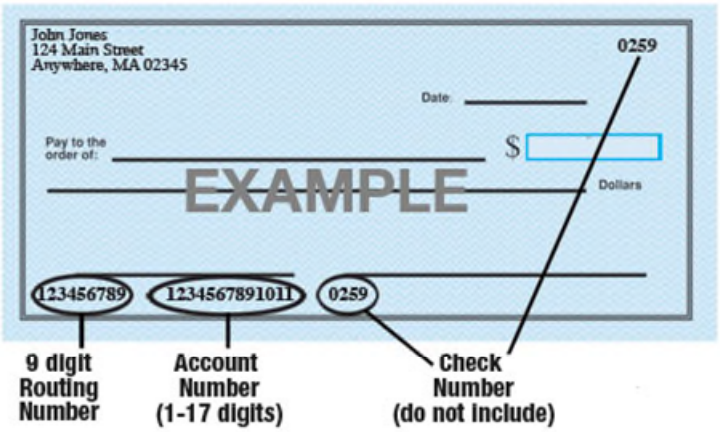
Direct Deposit Authorization Form

Please print and complete ALL the information below for Short Term Disability Direct Deposits

Name: _____**UBC:** _____

Address: _____**City, State, Zip**:_____

Cell Phone: _____ **Email:** _____



Name of Bank: _____

Account #: _____

9-Digit Routing #: _____

Type of Account: ☐ Checking ☐ Savings (Check One)

Attach a voided check for bank account to which funds should be deposited (if necessary)

NYCDCC Welfare Fund is hereby authorized to directly deposit my pay to the account listed above. This authorization will remain in effect until I modify or cancel it in writing.

Employee's Signature: _____

Date: _____