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New York State Court Clerks Association

Security Benefits Fund

170 DUANE STREET • NEW YORK, NY 10013
OFFICE: (212) 941-5700 • FAX: (212) 941-5705



Dear Member,

*We have received your request for Short Term Disability Insurance. Please be advised that under the terms of our Disability Policy, benefits are available for eligible members after a waiting period of **60 days**.*

The enclosed form must be completed, in the areas indicated, by you and your attending Physician.

*Please return the form along with a copy of your **time sheets for the entire period of illness indicated to:***

Rocco De Santis

First Vice President

New York State Court Clerks

170 Duane Street


New York, NY 10013

NEW YORK STATE COURT CLERKS ASSOCIATION

INITIAL CLAIM FOR SHORT TERM DISABILITY BENEFITS

CLAIMANT'S STATEMENT

CLAIMANT'S STATEMENT AND AUTHORIZATION MUST BE COMPLETED BY THE CLAIMANT OR LEGAL REPRESENTATIVE

Full Name _____ Date of Birth _____ Sex Male Female Social Security No. 

Street Address _____ State _____ Zip Code _____ Phone Number (Area Code) (____) _____ Employer _____

City or Town _____ Occupation _____ Date last worked _____

Marital Status: Single Married Widowed Divorced

Date sickness began or injury occurred _____

Date of first treatment by a physician for present disability _____

What injury or sickness caused your disability? _____

If injured, state fully how and where the injury occurred _____

Did injury occur while at work? Yes No

What duties are you now unable to perform? _____

I returned to work on a part-time basis on: (Mo. Da. Yr.) _____

I returned to work on a full-time basis on: (Mo. Da. Yr.) _____

Have you applied for any of the following benefits? _____

| Benefit Type | Yes/No | Yes/No | Amount of Benefit | Frequency |
|--|--|--|-------------------|--|
| Worker's compensation benefits or similar law benefit? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ _____ | <input type="checkbox"/> 1 Wk <input type="checkbox"/> 2 Wks |
| State disability benefits? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ _____ | _____ Wk |
| Social Security/Railroad Retirement benefits | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ _____ | _____ Month |

The undersigned certifies that the information disclosed above is true and correct

Several states require that this or a substantially similar statement appear on all claim forms:

"Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

AUTHORIZATION

I hereby authorize any provider of health care including but not limited to any physician, hospital or pharmacy of any employer, Social Security Administration, insurance company or other organization, institution, or person possessing information concerning _____ to permit the above named insurance company and its representative, insurance support organization, reinsurance companies or other persons performing business or legal services in connection with the claim, to view, copy be furnished copies or be given details of all such educational, vocational, physical or mental medical record information including but not limited to drug, alcohol, or psychiatric treatment or condition, AIDS, or the HIV virus, as well as information regarding employment income, other insurance coverage, and/or any otherwise personal or privileged information, including but not limited to any other claim for insurance benefits, or any records concerning civil or criminal proceedings.

I further authorize Daniel H. Cook Associates, Inc. to release all information related to this insurance claim to physicians, rehabilitation professionals, vocational evaluations, prospective employers, and any institution or person on a need to know basis for the purpose of verifying, evaluating, negotiating, and other pertinent uses with respect to my claim for benefits or service.

Any copy of the authorization shall have the same authority as original.

I understand I, or my authorized representative, may receive a copy of this authorization upon request. This authorization is for the duration of the claim.

SIGNATURE _____

DATE _____

Address _____

If signed on behalf of another, indicate relationship _____
a copy of document granting authority.

If Power of Attorney, Guardian, or Conservator, a _____

NEW YORK STATE COURT CLERK ASSOCIATION

THE PATIENT IS RESPONSIBLE FOR HAVING THE PHYSICIAN COMPLETE THIS FORM AND FOR ANY ASSOCIATED COST

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

1. Patient's Name _____ Age _____

2. (a) Height _____ (b) Weight _____ (c) Blood Pressure _____

3. Diagnosis (described complications, if any) _____

4. Has patient ever had same or similar condition? Yes No If yes, when _____

5. Is condition due to injury or sickness arising out of employment? Yes No If yes, explain _____

6. Is disability due to pregnancy? Yes No If yes, what was approximate date of commencement of pregnancy? _____

7. Nature of Treatment (including surgery and medication prescribed, if any) _____

8. Dates of treatments: Office _____
Home _____
Hospital _____

9. (a) Patient is now: totally partially disabled (b) For: Patient's Occupation Yes No
Any Other Work: Yes No

(c) Give the date from which the patient has been totally partially disabled _____

(d) When was or when will patient be able to return to work? _____ (e) Full-time Part-time

(f) What duties of patient's occupation is he/she INCAPABLE of performing? _____

10. Work Capacity

| | |
|---|--|
| <input type="checkbox"/> Sedentary work (10 lbs. lifting maximum) | <input type="checkbox"/> Heavy work (100 lbs. lifting maximum) |
| <input type="checkbox"/> Light work (20 lbs. lifting maximum) | <input type="checkbox"/> Very heavy work (lifting objects in excess of 100 lbs.) |
| <input type="checkbox"/> Medium work (50 lbs. lifting maximum) | |

11. REMARKS _____

ATTENDING PHYSICIAN CERTIFICATION

YOUR OPINION ON THE DEGREE OF DISABILITY IS ESSENTIAL. THEREFORE WE ASK THAT YOU, AS THE ATTENDING PHYSICIAN, PERSONALLY SIGN THIS REPORT.

Print or Type Name _____ Signature _____ Degree _____

Street Address _____ Medical Specialty _____

City or Town _____ State _____ Zip Code _____

MUST BE FURNISHED UNDER AUTHORITY OF LAW

Date _____ SSN or Employer's ID # _____

Telephone Number _____ FAX No _____