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 _____ Phone Number (Area Code) (___) _____

City or Town _____ State _____ Zip Code _____ Employer _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Occupation _____ Date last worked _____

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?

		If you have made application, are you receiving benefits?	Amount of Benefit
Worker's compensation benefits or similar law benefit?	☐ Yes ☐ No	☐ Yes ☐ No	$ _____ ☐ 1 Wk ☐ 2 Wks
State disability benefits?	☐ Yes ☐ No	☐ Yes ☐ No	$ _____ Wk
Social Security/Railroad Retirement benefits	☐ Yes ☐ No	☐ Yes ☐ 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

Solely to assist Daniel H. Cook Associates, Inc. in administering this claim, 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 _____ If Power of Attorney, Guardian, or Conservator, a copy of document granting authority.

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
    - ☐ Sedentary work (10 lbs. lifting maximum)
    - ☐ Light work (20 lbs. lifting maximum)
    - ☐ Medium work (50 lbs. lifting maximum)
    - ☐ Heavy work (100 lbs. lifting maximum)
    - ☐ Very heavy work (lifting objects in excess of 100 lbs.)
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 _____ SS# or Employer's ID # _____

Telephone Number _____ FAX No _____