New York City District Council of Carpenters

BENEFIT FUNDS

395 Hudson Street
New York, N.Y. 10014
Telephone: (212) 366-7300
Fax: (212) 366-7444

Dear Participant:

Enclosed please find an application for short-term disability benefits. This benefit is administered by the New York City District Council of Carpenters Welfare Fund. In order to process your application, please complete and sign **Part A** of the form. **Part B** is to be complete 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. Your completed application should be mailed to the Welfare Fund at the address noted above so that we can determine your eligibility for these benefits.

In the event your disability continues beyond an initial 26-week period, you may be entitled to disability benefits from the New York City District Council of Carpenters Pension Fund. In the past, the Welfare Fund has routinely provided the Pension Fund with a copy of your short-term disability application in order to initial the pension application process. However, the federal law known as HIPAA now prohibits the Welfare fund from disclosing your Protected Health Information to the Pension Funds without your specific authorization. Therefore, we are also enclosing an authorization form for this specific purpose. We will not initiate the pension application process without your signed authorization. You do have the option of contacting the Pension Fund yourself.

If you have any questions regarding this matter, please contact the Welfare Fund at 1-800-529-3863 and we will be happy to assist you.

Sincerely,

NYCDCC Welfare Fund

This individual noted below has submitted a claim for short-term disability benefits to the NYCDCC Welfare Fund. Please provide the information requested below:

1. Claimant's name:______________________________ UBC#:___________________________
2. City of New York Agency name:____
3. Address:____
4. Claimant's last day worked immediately before this disability:___________________________
5. Has Claimant returned to work? Yes___ No___
   a) If yes, give date:______________________
   b) If intermittent, give dates worked after disability began:________________
6. Will employee be paid for this leave of absence? Yes___ No___ If "yes", please provide a memo on company letterhead indicating the date payment will cease.
7. Is the disability related to the claimant's work or did the injury occur on you premises? Yes___ No___
8. In the spaces below, indicate the claimant's gross earnings during the eight calendar weeks prior to the week in which disability began;

Calendar week in which disability began	Omit this week
Prior week before disability....................	$___________
2nd Week before disability........................	$___________
3rd Week before disability........................	$___________
4th Week before disability........................	$___________
5th Week before disability........................	$___________
6th Week before disability........................	$___________
7th Week before disability........................	$___________
8th Week before disability........................	$___________

9. I certify the information given above is correct.

______________________________ _______________ ________________

SIGNITURE DATE TEL. #

______________________________ ____________________

PRINT FULL NAME TITLE

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

CLAIMANT: READ THE FOLLOWING INSTRUCTIONS CAREFULLY

1. USE THIS FORM IF YOU BECOME SICK OR DISABLED **WHILE EMPLOYED** OR IF YOU BECOME SICK OR DISABLED **WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT**. USE CLAIM FORM **DB-300** IF YOU **BECOME SICK OR DISABLED AFTER HAVING BEEN UNEMPLOYED MORE THAN FOUR (4) WEEKS**.
2. YOU MUST COMPLETE ALL ITEMS OF PART A - THE **"CLAIMANT'S STATEMENT"**. BE ACCURATE. CHECK ALL DATES.
3. BE SURE TO DATE AND SIGN YOUR CLAIM (SEE ITEM 12). IF YOU CANNOT SIGN THIS CLAIM FORM, YOUR REPRESENTATIVE MAY SIGN IT IN YOUR BEHALF. IN THAT EVENT, THE NAME, ADDRESS AND REPRESENTATIVE'S RELATIONSHIP TO YOU SHOULD BE NOTED UNDER THE SIGNATURE.
4. **DO NOT MAIL THIS CLAIM UNLESS YOUR HEALTH CARE PROVIDER COMPLETES AND SIGNS PART B - THE "HEALTH CARE PROVIDER'S STATEMENT."**
5. YOUR COMPLETED CLAIM SHOULD BE MAILED **WITHIN THIRTY (30) DAYS AFTER YOU BECOME SICK OR DISABLED TO YOUR LAST EMPLOYER OR YOUR LAST EMPLOYER'S INSURANCE COMPANY.**
6. MAKE A COPY OF THIS COMPLETED FORM FOR YOUR RECORDS BEFORE YOU SUBMIT IT.

PART A - CLAIMANT'S STATEMENT (Please Print or Type) ANSWER ALL QUESTIONS

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

1. My name is...
   First Middle Last
2. Address...
   Number Street City or Town State Zip Code Apt. No.
3. Tel. No.. 4. Date of Birth .... 5. Married (Check one) ☐Yes ☐No
6. My disability is (if injury, also state how, when and where it occurred) ....
   ....
7. I became disabled on .... a. I worked on that day ☐ Yes ☐No
   Month Day Year
   b. I have since worked for wages or profit. ☐ Yes ☐ No If "Yes", give dates ....
8. Give name of last employer. If more than one employer during the last eight (8) weeks, name all employers.

EMPLOYER'S			DATES OF EMPLOYMENT						AVERAGE WEEKLY WAGES (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
			FROM			THROUGH			
BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	Mo.	Day	Yr.	Mo.	Day	Yr.	

9. My job is or was ....
   Occupation Name of Union and Local Number, if Member
10. 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) Unemployment Insurance Benefits.. ☐ Yes ☐ No
       (3) Damages for personal injury.. ☐ Yes ☐ No
       (4) Benefits under the Federal Social Security Act for long-term disability .... ☐ Yes ☐ No

    IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 10a OR 10b, COMPLETE THE FOLLOWING:
    I have ☐ received ☐ claimed from .... for the period .... to........................
    Date Date
11. 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 .... To ....
    Date Date
12. I have read the instructions above. I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled; and that the foregoing statements, including any accompanying statements, are to the best of my knowledge true and complete.

    ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

    Claim signed on ....
    Date Claimant's Signature

    If signed by other than claimant, print below: name, address, and relationship of representative.

    ....

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, or an original signed, notarized authorization letter. You may telephone your local WCB office to have Form OC-110A sent to you, or you may download it from our web page, www.wcb.state.ny.us. It can be found under the heading Common Forms Online. Mail the completed authorization form or letter to the address given below.

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 DUDAS RELACIONADAS CON LA RECLAMACIÓN DE BENEFICIOS POR INCAPACIDAD, COMUNIQUESE CON LA OFICINA MÁS CERCANA DE LA JUNTA DE COMPENSACIÓN OBRERA DE NUEVA YORK, O ESCRIBA A: WORKER'S COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY- MENANDS, ALBANY, NY 12241-0005

HEALTH CARE PROVIDER MUST COMPLETE PART B ON REVERSE

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

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 CLAIM FORM DB-300.

PART B - HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type)

THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY AND THE FORM MAILED TO THE INSURANCE CARRIER OR SELF-INSURED EMPLOYER, OR RETURNED TO THE CLAIMANT WITHIN SEVEN DAYS OF THE RECEIPT OF THE FORM. For item 7d, give approximate date. Make some estimate. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date under "Remarks".

1. Claimant's Name .... 2. Date of Birth .... 3. Sex ❑ Male ❑ Female
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 be able to perform usual work			

   (Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)

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 form C-4 been filed with the Workers' Compensation Board? ❑ Yes ❑ No
   Remarks (attach additional sheet, if necessary) ....
   (If disability is pregnancy related, please enter estimated delivery

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

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

Health Care Provider's Signature .... Date ....
Health Care Provider's Name (Please Print) .... Tel.No. ....
Office Address ....
Number Street City or Town State Zip

HIPAA NOTICE - In order to adjudicate a workers' compensation claim, WCL13-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 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.

Return completed form with copies of last 8 weeks of pay stubs to:

NYCDCC Welfare Fund
395 Hudson Street
New York, NY 10014
Attn: Disability

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

NEW YORK CITY DISTRICT COUNCIL OF CARPENTERS WELFARE FUND

AUTHORIZATION FORM

For Use of Disclosure of Protected Health Information

PURPOSE OF THIS FORM

Under the Health Insurance Portability & Accountability Act (HIPAA), in order for the Welfare Fund to use or disclose Protected Health Information to someone other than you, you must complete this Authorization Form and return it to the Fund.

Protected Health Information "PHI" is information that is created, received, transmitted or stored by the Fund which relates to your past, present, or future physical or mental health, health care, or payment for health care, and either identifies you or provides a reasonable basis for identifying you. Except as permitted by law, the Fund may not use or disclose PHI to persons other than those you specify on this form.

The Fund may request that you complete this form where the use of disclosure of information is necessary to carry out functions of the Fund. In addition, you may submit this form to the Fund because you want someone to request or receive your PHI from the Fund. This form is not needed if you are requesting your own PHI from the Fund.

Name: ______________________________ UBC#______________________________

I hereby give permission to the Welfare Fund, or any of its affiliates or agents and their staff performing services in connection with my claim for health plan benefits, to disclose my protected health information (PHI) identified in Section #3 of this Form to the following class persons:

Spouse______________________________

Employer or the Fund New York City District Council of Carpenters Pension Fund__________________

Business Manager, Union Official or Agent______________________________

Other Person(s) New York County Health Services Review Organization/Med Review________________

I authorize the Welfare Fund to disclose PHI (including written, electronic, or oral information) to the person(s) identified in Section #2 of this form in connection with (mark all that apply): (if you want different people to have access to different information, you must fill out separate forms.)

__ Hospital/Medical Claims
__ Prescription Drug Claims
__Vision Claims
__ Mental Health Claims
__ Dental Claims
__ Hearing Aid Claims
__ Specific claim for health benefits
__ Disability Claim information

(describe the event or claims involved with the date of service)

____

____

The purpose of the use of disclosure of my protected health information (PHI) is:

____

____

____

NOTE: "at the request of the individual" is a sufficient description of the purpose.

This Authorization form is valid until:

1. ____ (please provide date of event);
2. The date the Fund receives my Cancellation of Authorization Form; or
3. If not otherwise indicated in (1) above, one year from the date I sign this form.

I understand that:

- I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION FORM.
- I HAVE THE RIGHT TO REVOKE THIS FORM AT ANY TIME BY SUBMITTING A CANCELLATION OF AUTHORIZATION FORM TOP THE WELFARE FUND. CANCELLATION WILL TAKE EFFECT AS OF THE CANCELLATION DATE OR EVENT, OR ONCE THE WELFARE FUND RECEIVES THE CANCELLATION OF AUTHORIZATION FORM.
- THE PERSON(S) I AM AUTHORIZING TO RECEIVE MY PHI MAY NOT BE REQUIRED TO TREAT THIS INFORMATION AS CONFIDENTIAL.
- TREATMENT, PAYMENT, ENROLLMENT AND ELIGIBILITY FOR BENEFITS MAY NOT BE CONDITIONED ON OBTAINING AN AUTHORIZATION.

____ ________________________________

Your Signature (or Signature of Personal Representative*) Date

*If you are acting as the personal representative of the individual whose PHI is to be disclosed, you must provide proof of your authority to act for that individual.