# GUIDEBOOK

## For City Injuries and Illness

City of Plattsburgh
Fire Department

**SECTION ONE**
**FAMILY MEDICAL LEAVE ACT (FMLA)**

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**SHORT-TERM DISABILITY INSURANCE**

**Prepared By:**
**Human Resources**
City of Plattsburgh
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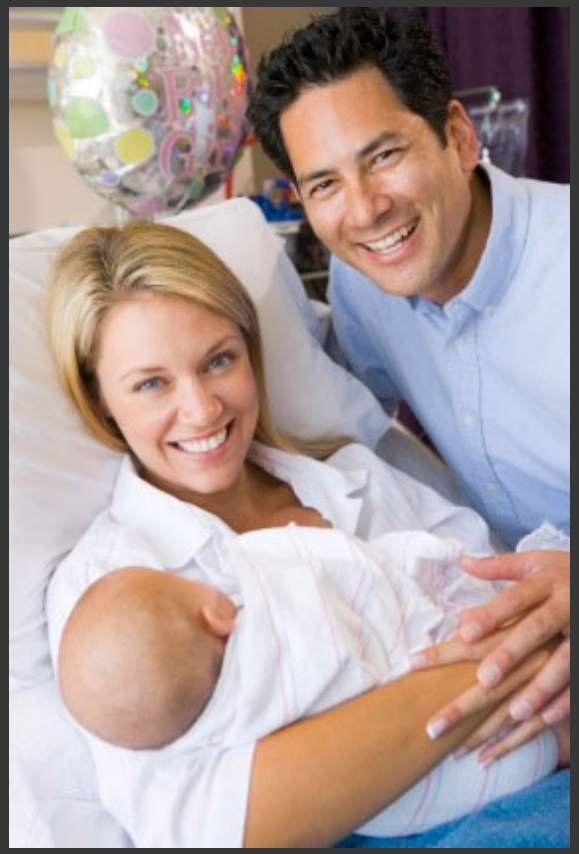
Plattsburgh, NY 12901

# FMLA

*Family and Medical Leave Act*



SECTION ONE

# WHAT IS FMLA?

The Family and Medical Leave Act of 1993 (FMLA) is a U.S. federal law requiring covered employers to provide employees job-protected, unpaid leave for qualified medical and family reasons.

The FMLA was intended to 'balance the demands of the workplace with the needs of families.

The Act allows eligible employees to take up to 12 work weeks of unpaid leave during any 12-month period to attend to the serious health condition of the employee, parent, spouse or child, or for pregnancy or care of a newborn child, or for adoption or foster care of a child.

Please see FAQs on page 7 for more specific information on FMLA or call Human Resources (536-7527)

# FMLA FORMS

Notice of Eligibility and Rights & Responsibilities
(Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

WHD
U.S. Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 2/28/2015

In general, to be eligible an employee must have worked for an employer for at least 12 months, meet the hours of service requirement in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c).

**[Part A – NOTICE OF ELIGIBILITY]**

TO: _____
Employee

FROM: _____
Employer Representative

DATE: _____ _____

On _____, you informed us that you needed leave beginning on _____ for:

____ The birth of a child, or placement of a child with you for adoption or foster care;

____ Your own serious health condition;

____ Because you are needed to care for your ____ spouse; ____child; _____ parent due to his/her serious health condition.

____ Because of a qualifying exigency arising out of the fact that your ____ spouse; ____son or daughter; _____ parent is on covered active duty or call to covered active duty status with the Armed Forces.

____ Because you are the ____ spouse; ____son or daughter; _____ parent; _____ next of kin of a covered servicemember with a serious injury or illness.

This Notice is to inform you that you:

____ Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)

____ Are **not** eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):

- ____ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately___ months towards this requirement.
- ____ You have not met the FMLA's hours of service requirement.
- ____ You do not work and/or report to a site with 50 or more employees within 75-miles.

If you have any questions, contact _____ or view the FMLA poster located in _____.

**[PART B-RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE]**

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by _____.** (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

____ Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to suport your request ___is/___ is not enclosed.

____ Sufficient documentation to establish the required relationship between you and your family member.

____ Other information needed (such as documentation for military family leave): _____

____ No additional information requested

Page 1 CONTINUED ON NEXT PAGE Form WH-381 Revised February 2013

## WH-381 Eligibility Notice FORM

**To inform employee that they have met the eligibility requirements for FMLA**

Certification of Health Care Provider for Employee's Serious Health Condition
(Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

WHD
U.S. Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 2/28/2015

**SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached: ____

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: RICHARD TUCKER
First Middle Last

**SECTION III: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax:(_____)_____

Page 1 CONTINUED ON NEXT PAGE Form WH-380-E Revised January 2009

## WH-380E Medical Certification FORM

**Certification by a medical provider that employee's need for leave is a result of a serious medical condition**

# FMLA FORMS

Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

WHD
U.S. Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 2/28/2015

**SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: _____

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: _____
First Middle Last

Name of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____ _____
Employee Signature Date

Page 1 CONTINUED ON NEXT PAGE Form WH-380-F Revised January 2009

## WH-380F Medical Certification FORM

**Certification by medical provider that employee's need for leave is result of family member's serious medical condition**

Designation Notice (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

WHD
U.S. Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 2/28/2015

**Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).**

To: _____

Date: _____

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided.
We received your most recent information on _____ and decided:

____ **Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.**

**The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:**

____ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: _____

____ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

**Please be advised (check if applicable):**

____ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

____ We are requiring you to substitute or use paid leave during your FMLA leave.

____ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position ___ **is** ___ **is not** attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

____ **Additional information is needed to determine if your FMLA leave request can be approved:**

____ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than _____, unless it is not
(Provide at least seven calendar days)
practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

_____
(Specify information needed to make the certification complete and sufficient)

_____

____ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

____ Your FMLA Leave request is Not Approved.
____ The FMLA does not apply to your leave request.
____ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 – 30 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

Form WH-382 January 2009

## WH-382 Designation Notice FORM

**Provides employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).**

# FORMS TO FILE – FIRE DEPARTMENT

| TYPE OF INJURY | CONDITIONS | FORMS TO COMPLETE | WHO COMPLETES FORM? | FILE COMPLETED FORN WITH YOUR RECORDS AND…. |
|---|---|---|---|---|
| WORK-RELATED | NO LOSS OF TIME and NO MEDICAL CARE SOUGHT | INJURY REPORT | Employer | Email copy to HR |
| | | C-2F | Employer | Email copy to HR |
| | | §207A | Employer | File at Fire Department |
| WORK-RELATED | NO LOSS OF TIME and MEDICAL CARE SOUGHT | INJURY REPORT | Employer | Email copy to HR |
| | | C-2F | Employer | Email copy to HR |
| | | C-3 or C-3.3 | EMPLOYEE | Email copy to WCB |
| | | §207A | Employer | File at Fire Department |
| WORK-RELATED | LOSS OF TIME and MEDICAL CARE SOUGHT | INJURY REPORT | Employer | Email copy to HR |
| | | C-2F | Employer | Email copy to HR |
| | | C-3 or C-3.3 Claim Form | EMPLOYEE | Email copy to HR |
| | | C-11 Change of Status Form | Employer | Complete when employee returns to work, discontinues work, increases or decreases regular hours of work and there is an increase or reduction of wages |
| | | §207A | Employer | File at Fire Department |
| | | FMLA<br>All employees who are out for more than 3 days for on-duty (WC) or off-duty (Short-Term Disability) injuries/illness should be placed on FMLA | PHYSICIAN<br>HR | HR administers all FMLA forms |
| | | RPCF complete RPCF for employees on WC or Disability who will be out of the workforce for more than 3 days. Indicate Paid or Unpaid on RPCF | EMPLOYER | Email copy of RPCF to HR<br>This will alert HR to place employee on FMLA |

# FREQUENTLY ASKED QUESTIONS

## FAMILY MEDICAL LEAVE ACT (FMLA)

### How are leaves covered under FMLA ?

FMLA is a mandatory federal leave law to protect employees who need to take time off from work to attend to certain family and medical problems. It applies to employers with 50 or more employees and all public agencies and schools . FMLA allows an eligible employee to take up to 12 work weeks of job-protected , unpaid leave for various family and medical reasons, including medical leave when the employee is unable to work because of a "serious health condition."

### Should employers give the employee special notification under FMLA?

The employer must notify the employee, in writing, that the WC leave is designated as FMLA leave and will count against, and run concurrently with, the employee's 12-week FMLA entitlement. Most employers use form WH-381E Eligibility Form to inform employees that they are eligible for FMLA. They use WH-382 Designation Notice to inform employees that they are designated on FMLA. They provide physicians with WH-380 Medical Certification form to verify a 'serious medical illness.'

### Who can take FMLA leave?

In order to be eligible for FMLA leave, an employee must:

- work for a covered employer;
- have worked 1250 hours during 12 months prior to start of leave;
- work at a location where employer has 50 or more employees within 75 miles;
- have worked for the employer for 12 months (not required to be in consecutive order).

### Does time I take off for vacation, sick, personal leave count toward 1250 hours?

The 1250 hours include only those hours actually worked for the employer. Paid leave and unpaid leave, including FMLA leave, are not included.

### Is my employer required to pay me when I take FMLA leave?

FMLA only requires unpaid leave. However, the law permits an employee to elect, or the employer to require the employee to use accrued paid vacation, sick, personal for some or all of the FMLA leave period. An employee must follow the employer's normal leave rules in order to substitute paid leave.

### How do collective bargaining agreements (CBA's) affect FMLA regulations?

Employer must observe any employment benefit program that provides greater family or medical leave rights to employees than the rights established by FMLA.

### When can an eligible employee use FMLA leave?

A covered employer must grant an eligible employee up to a total of 12 workweeks of unpaid, job-protected leave in a 12 month period for one or more of the following reasons:

- For the birth of a son or daughter, and to bond with the newborn child
- For the placement with the employee of a child for adoption or foster care, and to bond with that child;
- To care for an immediate family member (spouse, child, parent, but not parent-in-law) with a serious health condition
- To take medical leave when the employee is unable to work because of a serious health condition;
- For qualifying emergencies arising from employee's spouse, son, daughter, or parent on covered active duty or call to covered active duty as member of National Guard, Reserves, or Regular Armed Forces.

### Who does FMLA <u>not</u> apply to?

The FMLA does not apply to:

- Workers in businesses with fewer than 50 employees (threshold not applied to public and local educational agencies employees);
- part-time workers who have worked fewer than 1,250 hours within the 12 months preceding the leave and a paid vacation;
- Workers who need time off to care for seriously ill elderly relatives (other than parents) or pets;
- Workers who need time off to recover from short-term or common illness like a cold, or to care for a family member with a short-term illness;
- elected officials; and
- Workers who need time off for routine medical care, such as check-ups.

### What is a serious health condition?

The most common serious health conditions that qualify for FMLA leave are:

- Conditions requiring an overnight stay in a hospital or other medical care facility;
- Conditions that incapacitate you or your family member for more than 3 consecutive days and have ongoing medical treatment
- Chronic conditions that cause occasional periods when you or family member are incapacitated and require treatment by health care provider at least twice a year;
- Pregnancy (including prenatal medical appointments, incapacity due to morning sickness, and medically required bed rest.

### Can I use paid leave as FMLA leave?

An employee may choose to substitute accrued paid leave for unpaid FMLA leave if the employee complies with terms and conditions of employer's applicable paid leave policy. If the employee does not choose to substitute applicable accrued paid leave, the employer may require the employee to do so.

# FREQUENTLY ASKED QUESTIONS

## SPECIFIC TO CITY FIRE DEPARTMENT EMPLOYEES

| | FMLA | GMU §207A | CBA FIRE | NYS Workers' Compensation |
|---|---|---|---|---|
| Is City required to maintain healthcare benefits for City firefighters injured on the job? | **YES, under FMLA**<br>A covered employer is required to maintain group health insurance coverage for employees on FMLA leave whenever such insurance was provided before the leave was taken. Insurance is provided on the same terms as if the employee had continued work. | **NO, under §207A**<br>There is no provision for maintenance of healthcare benefits for firefighters under GMU §207A | **YES, under Fire CBA**<br>CBA, ARTICLE VII, Section 4i. Leave of Absence, page 29 states: "The City agrees to continue to provide health insurance coverage for employees on medical leaves of absence providing the employee reimburses the City for the cost of said health insurance each month the employee is on said leave." | **NO, under Workers' Comp**<br>Workers' Comp does not require employers to maintain health care benefits for employees unless the employee is covered on FMLA while out on Workers' Comp, then the employer is required to maintain health insurance for the duration of FMLA.<br><br>If an employee is out on Workers' Comp, and is out of leave accruals and is not being paid by the City and only being paid by Workers Comp (direct comp), he/she must make arrangements with Payroll to pay his/her share of the healthcare premium. |
| Is City required to maintain full, regular wages for City firefighters injured on the job? | **NO, under FMLA**<br>FMLA is unpaid leave. Employers have the option of mandating that employees use leave accruals while on FMLA which would provide employees with wages. | **YES, under §207A**<br>If awarded §207A, a Firefighter is entitled to full, regular salary or wages until the work-related disability ceases. | **YES, under Fire CBA**<br>If awarded §207A, a Firefighter is entitled to full, regular salary or wages until the work-related disability has ceased. | **NO, under Workers' Comp**<br>Workers' Comp only provides a maximum indemnity of 2/3 AWW adjusted by severity of injury with a current maximum of $808.65 (7/1/2014 to 6/30/2015) .<br><br>Workers' Comp does not provide for full regular salary or wages—only partial wages as per above. |
| Is City required to restore City firefighters injured on the job to their original job or to an equivalent job after their return from leave? | **YES, under FMLA**<br>Upon return from FMLA leave, an employee must be restored to the employee's original job, or to an equivalent job with equivalent pay, benefits, and other terms and conditions of employment. There is NO undue hardship exception. | **NO, under §207A**<br>There are no provisions under GMU §207A that provide for job restoration to original job or to an equivalent job following return from work-related injury. | **NO, under Fire CBA**<br>There are no provisions under Fire Department CBA that provide for job restoration to original job or to an equivalent job. However, CBA ARTICLE XVIII, Section 5a. Assignment to Light Duty, page 43 states: "If upon examination by the City's physician(s) the firefighter is able in their opinion to perform the specified light duty as is provided for herein, the firefighter may be assigned a light duty assignment." | **NO, under Workman's Comp**<br>Employers are only required to keep employee employed until he/she recovers or reaches MMI (Maximum Medical Improvement).<br><br>There is no guarantee of job restoration to original job or equivalent job with equivalent pay, benefits and other terms/conditions of employment under NYS Workers' Comp. There are no reinstatement rights under NYS WC laws, except for retaliatory discharges.<br><br>Employer is required, under ADA to make reasonable efforts to accommodate employee's new work restrictions so that he/she can perform their job. If employer can reasonably accommodate employee, employer must accommodate employee. This is a requirement pursuant to the Americans with Disabilities Act (ADA). |

# WORKERS' COMPENSATION

## WORK-RELATED INJURY AND ILLNESS

SECTION TWO

# WHAT IS WORKERS' COMPENSATION?

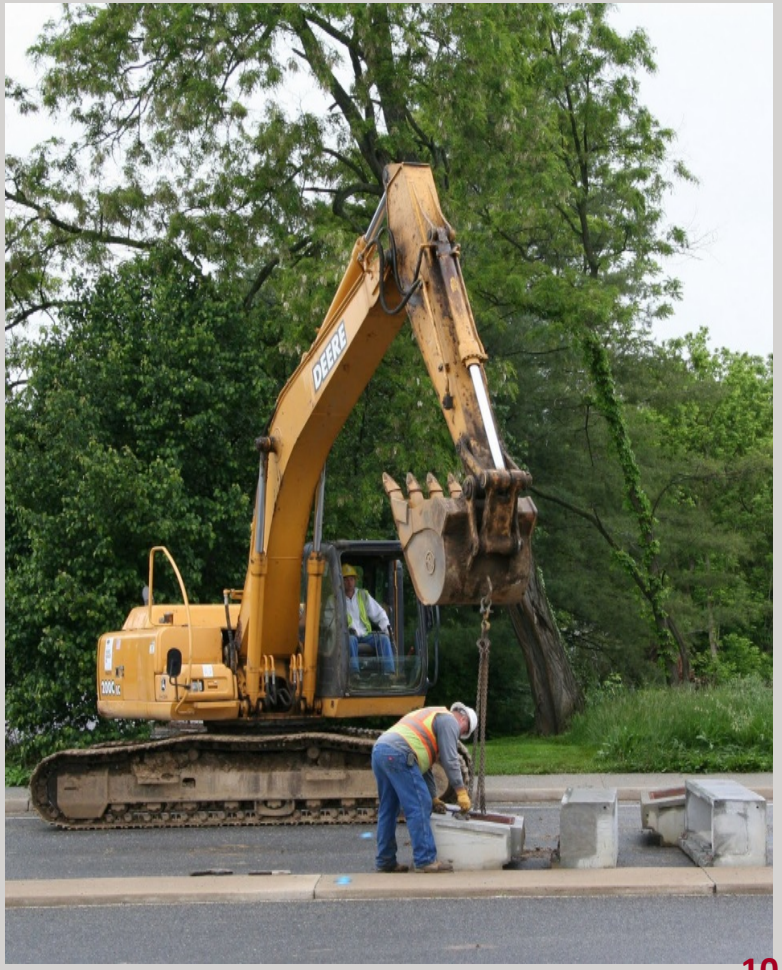
**Workers Comp statutes are primarily state liability and income continuation laws that protect employees who are injured while working.**

**Almost every state has a law that guarantees an income (funded by employers and the state) to employees injured on the job and at the same time, places limits on the employer's responsibility for the injury.**

**Benefits vary from state to state, but typically include medical treatment, rehabilitation, disability, and wage continuation. While plans differ among jurisdictions, provision can be made for:**

- **Compensation** for economic loss (past and future)
- **Reimbursement or payment of medical and like expenses** (functioning in this case as a form of health insurance)
- **Benefits payable to the dependents of workers killed during employment** (functioning in this case as a form of life insurance)
- **Weekly payments in place of wages** (functioning in this case as a form of disability insurance)

**Please see FAQs on page 15 for more specific information on how FMLA interacts with Workers' Comp or call Human Resources (536-7527)**



# HOW DO EMPLOYERS FILE A WORKERS' COMP CLAIM?

**When a WORK-RELATED accident occurs, it is important for EMPLOYERS to report it as soon as possible.**
**Employers are required to file a C-2F within 10 days from accident notification by employee.**
**Employees can file a C-3 or C-3.3 within two (2) years of date of accident.**

| | | |
|---|---|---|
| **CLAIM FORM** | Employer Claim Reporting Form | **C-2F** |
| **FILE C-2F BY FAX** | Dedicated, toll-free FAX to report claim C-2F | **877-567-5730** |
| **FILE C-2F BY EMAIL** | Dedicated email address for emailing C-2F | **WCReporting@wrightrisk.com** |
| **File C-3 BY FAX** | Dedicated, toll-free FAX to report claim C-3 | **877-533-0337**<br>***If the employer faxes C-3 on behalf of employee, keep a copy of the fax confirmation in your records** |

## CITY OF PLATTSBURGH WORKERS' COMP SERVICES

**City of Plattsburgh is a member of the COMP ALLIANCE, which is a group, self-insured workers' compensation program.**

COMP ALLIANCE

333 Earle Ovington Blvd, Suite 505
Uniondale, NY 11553-3624

**Wright Risk Management serves as the management company providing the City of Plattsburgh with policyholder services, claims' services, and risk management services.**

WRIGHT™ Risk Management

333 Earle Ovington Blvd., Suite 505
Uniondale, NY 11553-3624

# WORKERS' COMPENSATION FORMS: C-2F, C-3

WORKERS' COMPENSATION BOARD

*State of New York - Workers' Compensation Board*

**Employer's First Report of Work-Related Injury/Illness**

**C-2F**

A work-related injury or illness must be reported within 10 days (Per Section 110) of the injury/illness or be subject to a penalty. Employers are not required to submit form C-2F to the Workers' Compensation Board if the employer's insurer will be submitting the accident information electronically to the Board on the employer's behalf. If you need assistance completing this form, please contact your insurer for guidance on the best method of reporting work-related accident information. If you submit this form to the Board, please send it to P.O. Box 5205, Binghamton, NY 13902 and provide a copy to your insurer.

Employee Name _____

WCB Case Number (JCN) _____ Date of Injury _____

Claim Administrator Claim Number _____

**INSURER / CLAIM ADMINISTRATOR INFORMATION**

Insurer Name _____ Insurer ID _____

Name _____

Info/Attn _____

Address _____

City _____ State _____

Postal Code _____ Country _____

Claim Admin ID _____

**EMPLOYEE INFORMATION**

First Name _____ Middle Name/Initial _____

Last Name _____ Suffix _____

Mailing Address _____

City _____ State _____

Postal Code _____ Country _____

Phone Number _____ Date of Hire _____

Date of Birth _____ Gender ☐ Male ☐ Female ☐ Unknown

Employee SSN _____

Occupation Description _____

C-2F (5-13) Page 1 of 3 www.wcb.ny.gov

## C-2F Claim FORM

**Work-related injury or illness report within 10 days as required by §110.**

WORKERS' COMPENSATION BOARD

**Employee Claim**

*State of New York - Workers' Compensation Board*

**C-3**

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.ny.gov.

WCB Case Number (if you know it): _____

**A. YOUR INFORMATION (Employee)**

1. Name: _____ (First, MI, Last) 2. Date of Birth: ___/___/___
3. Mailing address: _____ (Number and Street/PO Box, City, State, Zip Code)
4. Social Security Number: ___-___-___ 5. Phone Number: (___)_____ 6. Gender: ☐ Male ☐ Female
7. Will you need a translator if you have to attend a Board hearing? ☐ Yes ☐ No If yes, for what language? _____

**B. YOUR EMPLOYER(S)**

1. Employer when injured: _____ 2. Phone Number: (___)_____
3. Your work address: _____ (Number and Street, City, State, Zip Code)
4. Date you were hired: ___/___/___ 5. Your supervisor's name: _____
6. List names/addresses of any other employer(s) at the time of your injury/illness: _____
7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

**C. YOUR JOB on the date of the injury or illness**

1. What was your job title or description? _____
2. What types of activities did you normally perform at work? _____
3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: _____
4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____
6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: _____

**D. YOUR INJURY OR ILLNESS**

1. Date of injury or date of onset of illness: ___/___/___ 2. Time of injury: _____ ☐ AM ☐ PM
3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____
4. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? _____
5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____
6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____
7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

C-3.0 (1-11) Page 1 of 2 THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION www.wcb.ny.gov

## C-3 Claim FORM

**To apply for WC benefits as a result of a work injury or work-related illness.**

# WORKERS' COMPENSATION FORMS: C-3.3, C-11

WORKERS' COMPENSATION BOARD

**Limited Release of Health Information**
(HIPAA)
*State of New York - Workers' Compensation Board*

**C-3.3**

WCB Case No. *(if you know it)*:_____

**To Claimant:** If you received treatment for a *previous* injury to the same body part or for an illness similar to the one described in your current Claim, fill out this form. This form allows the health care providers you list below to release health care information about your previous injury/illness to your employer's workers' compensation insurer. The federal HIPAA law (Health Insurance Portability and Accountability Act of 1996) says you have a right to get a copy of this form. If you do not understand this form, talk to your legal representative. If you do not have a legal representative, the Advocate for Injured Workers at the Workers' Compensation Board can help you. Call: 800-580-6665.

**To Health Care Provider:** A **copy** of this HIPAA-compliant release allows you to disclose health information. If you send records to the employer's workers' compensation insurer in response to this release, also mail copies to the Claimant's legal representative. (If no legal representative is listed below, send copies to the Claimant.) Health care providers who release records must follow New York state law and HIPAA.

This release is:

- **Voluntary.** Your health care provider(s) must give you the same care, payment terms, and benefits, whether you sign this form or not.
- **Limited.** It gives your health care provider(s) permission to release only those health records that are related to the previous illness/condition you describe below.
- **Temporary.** It ends when your current claim for compensation is established or disallowed and all appeals are exhausted.
- **Revocable.** You can cancel this release at any time. To cancel, send a letter to the health care provider(s) listed on this form. Also, send a copy of your letter to your employer's workers' compensation insurer and the Workers' Compensation Board. *Note: You may not cancel this release with respect to medical records already provided.*
- **For records only.** It gives your health care provider(s) listed on this form permission to send copies of your health care records to your employer's workers' compensation insurer.

This form does NOT allow your health care provider(s) to release the following types of information:

- **HIV-related information**
- **Psychotherapy notes**
- **Alcohol/Drug treatment**
- **Mental Health treatment** (unless you check below)
- **Verbal information** (your health care providers may not discuss your health care information with anyone)

Any medical records released will become part of your workers' compensation file and are confidential under the Workers' Compensation Law.

**A. YOUR INFORMATION (Claimant)**

1. Name:_____ 2. Social Security Number:____-____-____
3. Mailing Address: _____
4. Date of Birth: ____/____/____ 5. Date of the current injury/illness: ____/____/____
6. Current injury/illness, including all body parts injured:_____
7. Your legal representative's name and address (if any):_____

☐ *Check here if you allow your health care provider(s) to release* ***mental health care*** *information.*

**B. YOUR HEALTH CARE PROVIDER(S)** (List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers attach their contact information to this form.)

1. Provider:_____ 2. Phone Number: (____)_____
3. Mailing Address: _____
4. Other provider (if any):_____ 5. Phone Number: (____)_____
6. Mailing Address:_____

**C. READ AND SIGN BELOW.** I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above.

_____
Claimant's signature (ink only – use blue ballpoint pen, if possible) Date

**If the claimant is unable to sign,** the person signing on his/her behalf must fill out and sign below:

_____
Your name Relationship to Claimant Signature (ink only – use blue ballpoint pen, if possible) Date

C-3.3 (12-09) Versión en español al reverso de la forma. www.wcb.ny.gov

## C-3.3 Health Information FORM

**To allow the health care providers you selected to release health care information about your previous injury/illness to your employer's WC insurer. Employee completes if there is a re-injury to the same body part.**

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

**EMPLOYER'S REPORT OF INJURED EMPLOYEE'S CHANGE IN EMPLOYMENT STATUS RESULTING FROM INJURY**

This report is to be filed directly with the Chair, Workers' Compensation Board at the address shown on reverse side as soon as the employment status of an injured employee, as reported on First Report of Injury, or on a previous Form C-11 or EC-11, is changed. Change in employment status includes return to work, discontinuance of work, increase or decrease of regular hours of work and increase or reduction of wages. **A copy should also be sent to your insurance carrier.**

| ALL COMMUNICATIONS SHOULD REFER TO THESE NUMBERS | | 3. Carrier Code | 4. Date of Injury | 5. Claimant's Soc. Sec. No. |
|---|---|---|---|---|
| 1. W.C.B. Case Number | 2. Carrier Case Number | | | |
| | | | | |

| | Name | Address to which notice should be sent (Give Number and Street, City, State, and Zip Code) | |
|---|---|---|---|
| 6. Injured Person | | | Apt.No. |
| 7. Employer | | | |
| 8. Carrier | | | |

9. Date of most recent Employer's Report filed:(check "x" & give date filed) ☐ First Report of Injury _____ ☐ C-11/EC-11 _____

10. Date of first full day employee lost from work: _____ 11. Nature of Injury:_____

12. Date employee returned to work: _____

13. (a) Change of employment status resulting from above injury:

| Employment Status | Hours per Day | Days per Week | Earnings | Occupation |
|---|---|---|---|---|
| Prior To Injury | | | | |
| Changed To | | | | |

(b) Date of this change in employment status:_____ (c) Remarks:_____

14. Loss of time resulting from above injury since first return to work:

| From (Mo., Day, Year) | To (Mo., Day, Year) | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

15. Is injured person still under physician's care?_____ If yes, give name of physician:_____

16. Has injured person died?_____ If yes, give date of death:_____

Name and address of nearest known relative:_____

Date of this Report_____ Tel. No._____Firm Name_____

Prepared By:_____ Official Title_____

C-11 (1-11) C-11 C-11 C-11 C-11

## C-11 Employer's Report FORM

**To communicate the change in employment status of an injured employee, as reported in C-2, or a previous C-11 Form.**

# FORMS TO FILE – FIRE DEPARTMENT

| TYPE OF INJURY | CONDITIONS | FORMS TO COMPLETE | WHO COMPLETES FORM? | FILE COMPLETED FORN WITH YOUR RECORDS AND…. |
|---|---|---|---|---|
| WORK-RELATED | NO LOSS OF TIME and NO MEDICAL CARE SOUGHT | INJURY REPORT | Employer | Email copy to HR |
| | | C-2F | Employer | Email copy to HR |
| | | §207A | Employer | File at Fire Department |
| WORK-RELATED | NO LOSS OF TIME and MEDICAL CARE SOUGHT | INJURY REPORT | Employer | Email copy to HR |
| | | C-2F | Employer | Email copy to HR |
| | | C-3 or C-3.3 | EMPLOYEE | Email copy to WCB |
| | | §207A | Employer | File at Fire Department |
| WORK-RELATED | LOSS OF TIME and MEDICAL CARE SOUGHT | INJURY REPORT | Employer | Email copy to HR |
| | | C-2F | Employer | Email copy to HR |
| | | C-3 or C-3.3 Claim Form | EMPLOYEE | Email copy to HR |
| | | C-11 Change of Status Form | Employer | Complete when employee returns to work, discontinues work, increases or decreases regular hours of work and there is an increase or reduction of wages |
| | | §207A | Employer | File at Fire Department |
| | | FMLA<br>All employees who are out for more than 3 days for on-duty (WC) or off-duty (Short-Term Disability) injuries/illness should be placed on FMLA | PHYSICIAN<br>HR | HR administers all FMLA forms |
| | | RPCF complete RPCF for employees on WC or Disability who will be out of the workforce for more than 3 days. Indicate Paid or Unpaid on RPCF | EMPLOYER | Email copy of RPCF to HR<br>This will alert HR to place employee on FMLA |

# FREQUENTLY ASKED QUESTIONS

## WORKERS' COMP and FMLA

### How are leaves covered under FMLA ?

FMLA is a mandatory federal leave law to protect employees who need to take time off from work to attend to certain family and medical problems. It applies to employers with 50 or more employees and all public agencies and schools. FMLA allows an eligible employee to take up to 12 weeks of job-protected leave for various family and medical reasons, including medical leave when the employee is unable to work because of a serious health condition.

### Should employers give the employee special notification under FMLA?

The employer must notify the employee, in writing, that the Workers' Comp (WC) leave is designated as FMLA leave and will count against, and run concurrently with, the employee's 12-week FMLA entitlement. Most employers use WH-381E Eligibility Form to inform employees that they are eligible for FMLA. Form WH-382 Designation Notice informs employees that they are designated on FMLA. Physicians are provided with WH-380E Medical Certification form to verify an employee's 'serious medical illness' and WH-380F for verification of a family member's serious health condition.

### When is a Workers' Comp injury covered under FMLA ?

If employee is eligible for leave under FMLA for a 'serious medical condition,' WC leave should be treated under FMLA. Since the FMLA statute does not distinguish between work-related and non-work-related injuries, any on-the-job injury tat requires an employee to take leave to seek inpatient care or continuing treatment likely will be covered under FMLA.

### Does an employer have to pay for health insurance (HI) for an employee on WC leave?

If the employee qualifies for FMLA leave and the employer normally pays for HI, the answer is yes. Although most state WC laws do not require employers to pay for HI during a WC leave, FMLA requires the continuation of HI benefits during a FMLA leave. If the WC leave runs concurrently with FMLA, health care benefit continuance is required.

### Can an employee on WC Leave be required to use vacation or sick leave?

FMLA allows employers to require employees, or allows employees to elect to substitute accrued vacation, sick, or other paid leave for all or part of the 12 weeks of unpaid leave under FMLA.

### Does the employer have to reinstate an employee returning from a WC leave?

If covered under FMLA, employee must be reinstated to the same or an equivalent position. The employee must be reinstated even if the employer did not notify the employee of FMLA coverage.

### What happens if employee does not return to work after 12 weeks of FMLA leave?

If the employee does not return to work at the end of the 12-week FMLA leave, the employer may terminate the employee without violating FMLA as long as the termination is consistent with the treatment of similarly-situated employees who have taken FMLA leave. The employee must have been properly placed on FMLA leave and notified that the time off for WC leave ran concurrently with FMLA.

Further considerations: the employee may be considered disabled under the Americans with Disabilities Act (ADA), and therefore, may be entitled to additional leave as an accommodation.

### If I am <u>not</u> being paid by the employer and only by WC, do I have to pay my share of my healthcare premium?

If you are being paid directly from WC instead of receiving a check from the employer, in most cases, you will be required to pay for your portion of your health insurance premium. You must make arrangements with payroll to pay your weekly share of premium cost while you are on leave.

### Can I be fired while out on Workers Comp?

Your employer may not terminate you as a retaliation for a workers' comp claim. For contracted employees, your contract should list the specific reasons your employer may terminate you. Occupationally-injured employees have significant job protections under Civil Service Law. CSL § 71 provides that an employee be allowed leave due to an occupational injury or disease as defined in Workers' Comp Law. CSL § further provides that an occupationally disabled employee is entitled to a cumulative leave of absence of at least one year.

# ADA

## AMERICANS WITH DISABILITIES ACT

SECTION THREE

# WHAT IS THE ADA?

The Americans with Disabilities Act (ADA) became law in 1990. The ADA is a civil rights law that prohibits discrimination against individuals with disabilities in all areas of public life, including jobs, schools, transportation, and all public and private places that are open to the general public.

The purpose of the law is to make sure that people with disabilities have the same rights and opportunities as everyone else. The ADA is divided into FIVE TITLES (or sections) that relate to different areas of public life.

**TITLE 1: EMPLOYMENT (Equal Employment Opportunity for Individuals with Disabilities)** This title is designed to help people with disabilities access the same employment opportunities and benefits available to people without disabilities. Employers must provide reasonable accommodations to qualified applicants or employees. A "reasonable accommodation" is a change that accommodates employees with disability without causing the employer "undue hardship" (too much difficulty or expense). Regulated and Enforced by Department of Labor – EEOC Division

**TITLE II: STATE and LOCAL GOVERNMENT: (Nondiscrimination on the Basis of Disability in State and Local Government:** This title prohibits discrimination on the basis of disability by "public entities," which are programs, services and activities operated by state and local governments. The public entity must make sure its programs, services and activities are accessible to individuals with disabilities are paid. Regulated and Enforced by Department of Justice

**TITLE III PUBLIC ACCOMODATIONS (Nondiscrimination on the Basis of Disability by Public Accommodations and in Commerce)** This title prohibits private places of public accommodation from discriminating against individuals with disabilities. Examples of public accommodations include privately-owned, leased or operated facilities like hotels, restaurants, retail merchants, doctor's offices, golf courses, private schools, day care centers, health clubs, sports stadiums, movie theaters, and so on. Regulated/Enforced by US Department of Justice.

**TITLE IV TELECOMMUNICATIONS** This title requires telephone and Internet companies to provide a nationwide system of interstate and intrastate telecommunications relay services that allows individuals with hearing and speech disabilities to communicate over the telephone. This title also requires closed captioning of federally funded public service announcements. Regulated by FCC.

**TITLE V MISCELLANEOUS PROVISIONS** The final title contains a variety of provisions relating to the ADA as a whole, including its relationship to other laws, state immunity, its impact on insurance providers and benefits, prohibition against retaliation and coercion, illegal use of drugs, and attorney's fees. This title also provides a list of certain conditions that are not to be considered as disabilities

# FREQUENTLY ASKED QUESTIONS

## WORKERS COMPENSATION and ADA

**What employers are covered by title I of the ADA?**

The title I employment provisions apply to private employers, State and local governments, employment agencies, and labor unions with 15 or more employees.

**What practices and activities are covered by the employment nondiscrimination requirements?**

The ADA prohibits discrimination in all employment practices, including job application procedures, hiring, firing, advancement, compensation, training, and other terms, conditions, and privileges of employment.

**Who is protected from employment discrimination?**

Employment discrimination is prohibited against "qualified individuals with disabilities".

**What limitations does the ADA impose on medical examinations and inquiries about disability?**

An employer may not ask or require a job applicant to take a medical examination before making a job offer. An employer may, however, ask questions about the ability to perform specific job functions and may, with certain limitations, ask an individual with a disability to describe or demonstrate how s/he would perform these functions.

**What is "reasonable accommodation"?**

Reasonable accommodation is any modification or adjustment to a job or the work environment that will enable a qualified applicant or employee with a disability to participate in the application process or to perform essential job functions.

**When is an employer required to make a reasonable accommodation?**

An employer is only required to accommodate a "known" disability of a qualified applicant or employee. The requirement generally will be triggered by a request from an individual with a disability, who frequently will be able to suggest an appropriate accommodation.

**Are alcoholics covered by the ADA?**

Yes. While a current illegal user of drugs is not protected by the ADA if an employer acts on the basis of such use, a person who currently uses alcohol is not automatically denied protection. An alcoholic is a person with a disability and is protected by the ADA if s/he is qualified to perform the essential functions of the job. An employer may be required to provide an accommodation to an alcoholic. However, an employer can discipline, discharge or deny employment to an alcoholic whose use of alcohol adversely affects job performance or conduct. An employer also may prohibit the use of alcohol in the workplace and can require that employees not be under the influence of alcohol.

**How does the ADA affect workers' compensation programs?**

Only injured workers who meet the ADA's definition of an "individual with a disability" will be considered disabled under the ADA, regardless of whether they satisfy criteria for receiving benefits under workers' compensation or other disability laws. Work-related injuries do not always cause physical or mental impairments severe enough to "substantially limit" a major life activity. Therefore, many injured workers who qualify for benefits under workers' compensation or other disability benefits laws may not be protected by the ADA.

**What are an employer's recordkeeping requirements under the employment provisions of the ADA?**

An employer must maintain records such as application forms submitted by applicants and other records related to hiring, requests, for reasonable accommodation, promotion, demotion, transfer, lay-off or termination, rates of pay or other terms of compensation, and selection for training or apprenticeship for one year after making the record or taking the action described (whichever occurs later).

# SHORT-TERM DISABILITY INSURANCE

*FOR OFF-DUTY INJURY OR ILLNESS*

SECTION FOUR

# WHAT IS A SHORT-TERM DISABILITY?

The City of Plattsburgh provides full-time and part-time salaried employees with short-term disability income benefits should they become temporarily disabled off the job.

Temporarily disabled means the employee is not able to work for a short period of time due to sickness or injury not related to his or her job. The City pays the full cost of this benefit – except for Level 3 managers who contribute.

**Payments**: Short term disability insurance pays a percentage of the employee's salary if he/she becomes temporarily disabled.

**Waiting Period**: There is a 7 day waiting period before benefits are paid.

**Medical Verification**: The City's disability policy requires evidence from a physician that explains employee's condition and estimates how long they will be gone from the job.

**Use of Accruals**: Depending upon contract provisions, but in most cases, if the employee uses accruals and hence, is paid by the City, the disability insurance provider will pay the City and the employee will have his/her sick leave accruals credited back in terms of sick leave.

**Exceptions**: Many policies will not cover disabilities caused by suicide attempts, drug abuse, war, or attempts to commit a crime. Pre-existing conditions are also frequently excluded. On-the-job injuries, which are covered by workers' compensation insurance, also are not covered.

**Please see FAQs on page 24 for more specific information on Short-Term Disability or call Human Resources (536-7527)**

# WHAT COMPANY PROVIDES SHORT-TERM DISABILITY FOR CITY OF PLATTSBURGH

## Dearborn National Life Insurance Company

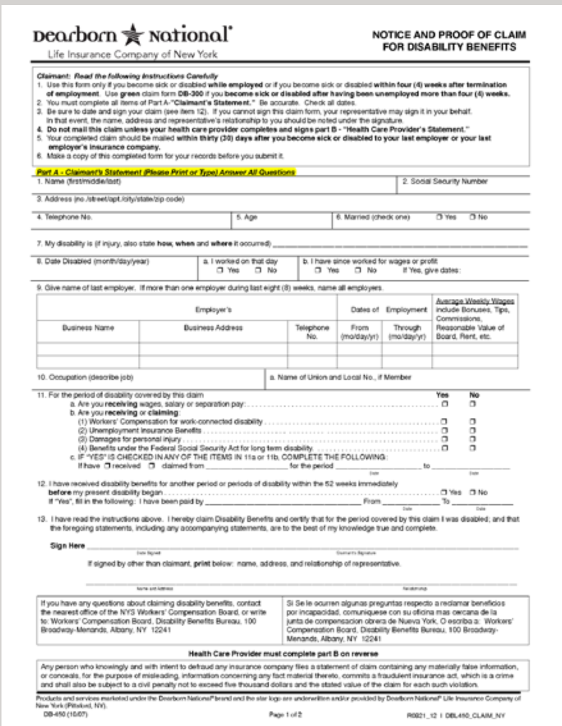
Dearborn National offers a broad selection of highly competitive insurance and financial products covering diverse markets, including: Group Benefits (employer-paid/voluntary), Worksite, Individual and an array of Enhanced Product Services.

The parent company of the Dearborn National brand companies, Health Care Service Corporation, a Mutual Legal Reserve Company, (HCSC) is the largest non-investor owned health insurer in the United States and the fourth largest overall.

First Niagara Benefits administers the Short-Term Disability policy for the City of Plattsburgh.

New York Disability Claim Office
85 Allen Street, Suite 201
Rochester, NY 14608
(800) 421-3711

# HOW DO EMPLOYERS & EMPLOYEES FILE A DISABILITY CLAIM? USE FORM DB-450



Dearborn National® Life Insurance Company of New York

**NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS**

***Claimant: Read the following Instructions Carefully***
1. Use this form only if you become sick or disabled **while employed** or if you become sick or disabled **within four (4) weeks after termination of employment**. Use **green** 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-**"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 - "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***

1. Name (first/middle/last) — 2. Social Security Number
3. Address (no./street/apt./city/state/zip code)
4. Telephone No. — 5. Age — 6. Married (check one) ❒ Yes ❒ No
7. My disability is (if injury, also state **how, when** and **where** it occurred)
8. Date Disabled (month/day/year) — a. I worked on that day ❒ Yes ❒ No — b. I have since worked for wages or profit ❒ Yes ❒ No If Yes, give dates:
9. Give name of last employer. If more than one employer during 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. |
|---|---|---|---|---|---|
| Business Name | Business Address | Telephone No. | From (mo/day/yr) | Through (mo/day/yr) | |
| | | | | | |
| | | | | | |

10. Occupation (describe job) — a. Name of Union and Local No., if Member
11. For the period of disability covered by this claim (Yes / No)
   a. Are you **receiving** wages, salary or separation pay ❒ ❒
   b. Are you **receiving** or **claiming**:
   (1) Workers' Compensation for work-connected disability ❒ ❒
   (2) Unemployment Insurance Benefits ❒ ❒
   (3) Damages for personal injury ❒ ❒
   (4) Benefits under the Federal Social Security Act for long term disability ❒ ❒
   c. IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 11a or 11b, COMPLETE THE FOLLOWING:
   If have ❒ received ❒ claimed from ______ for the period ______ to ______
12. 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 ______
13. 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.

**Sign Here** ______

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

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

Si Se le ocurren algunas preguntas respecto a reclamar beneficios por incapacidad, comuniquese con su 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

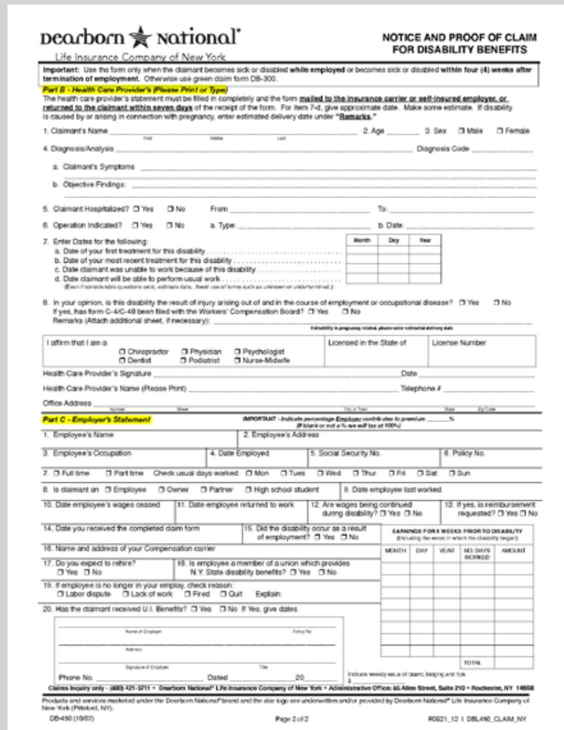
**Health Care Provider must complete part B on reverse**

Any person who knowingly and with intent to defraud any insurance company files a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company of New York (Pittsford, NY).

DB-450 (10/07) Page 1 of 2 R0821_12 I DBL450_CLAIM_NY

Claim Form DB-450 (page 1)



Dearborn National® Life Insurance Company of New York

**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 green claim form DB-300.

***Part B - Health Care Provider's (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 7-d, 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. Age ______ 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
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/C-48 been filed with the Workers' Compensation Board? ❒ Yes ❒ No
   Remarks (Attach additional sheet, if necessary):

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

Health Care Provider's Signature ______ Date ______
Health Care Provider's Name (Please Print) ______ Telephone # ______
Office Address ______

***Part C - Employer's Statement***

1. Employee's Name — 2. Employee's Address
3. Employee's Occupation — 4. Date Employed — 5. Social Security No. — 6. Policy No.
7. ❒ Full time ❒ Part time Check usual days worked: ❒ Mon ❒ Tues ❒ Wed ❒ Thur ❒ Fri ❒ Sat ❒ Sun
8. Is claimant an ❒ Employee ❒ Owner ❒ Partner ❒ High school student — 9. Date employee last worked
10. Date employee's wages ceased — 11. Date employee returned to work — 12. Are wages being continued during disability? ❒ Yes ❒ No — 13. If yes, is reimbursement requested? ❒ Yes ❒ No
14. Date you received the completed claim form — 15. Did the disability occur as a result of employment? ❒ Yes ❒ No
16. Name and address of your Compensation carrier
17. Do you expect to rehire? ❒ Yes ❒ No — 18. Is employee a member of a union which provides N.Y. State disability benefits? ❒ Yes ❒ No
19. If employee is no longer in your employ, check reason: ❒ Labor dispute ❒ Lack of work ❒ Fired ❒ Quit Explain:
20. Has the claimant received U.I. Benefits? ❒ Yes ❒ No If Yes, give dates.

EARNINGS FOR 8 WEEKS PRIOR TO DISABILITY

| MONTH | DAY | YEAR | NO. DAYS WORKED | AMOUNT |
|---|---|---|---|---|
| | | | | |
| | | | TOTAL | |

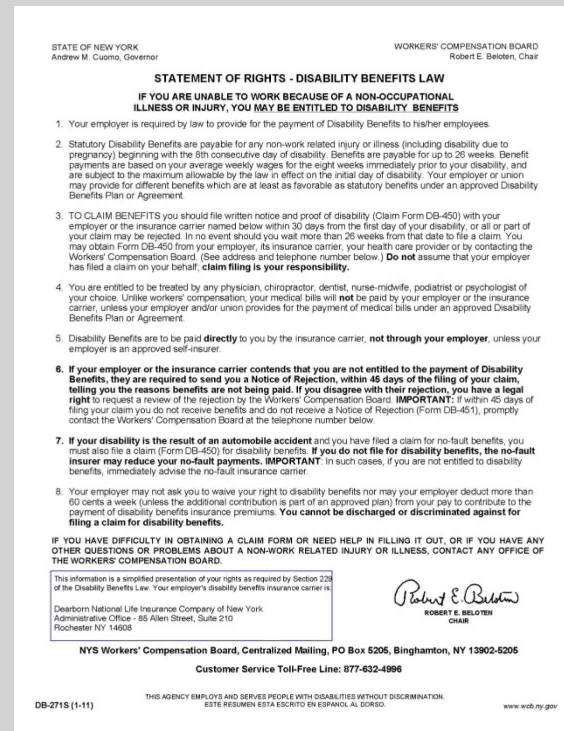
Phone No. ______ Dated ______ 20__

Claims Inquiry only - (800) 421-3711 • Dearborn National® Life Insurance Company of New York • Administrative Office: 85 Allen Street, Suite 210 • Rochester, NY 14608

Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company of New York (Pittsford, NY).

DB-450 (10/07) Page 2 of 2 R0821_12 I DBL450_CLAIM_NY

Claim Form DB-450 (page 2)



STATE OF NEW YORK
Andrew M. Cuomo, Governor

WORKERS' COMPENSATION BOARD
Robert E. Beloten, Chair

**STATEMENT OF RIGHTS - DISABILITY BENEFITS LAW**

**IF YOU ARE UNABLE TO WORK BECAUSE OF A NON-OCCUPATIONAL ILLNESS OR INJURY, YOU MAY BE ENTITLED TO DISABILITY BENEFITS**

1. Your employer is required by law to provide for the payment of Disability Benefits to his/her employees.
2. Statutory Disability Benefits are payable for any non-work related injury or illness (including disability due to pregnancy) beginning with the 8th consecutive day of disability. Benefits are payable for up to 26 weeks. Benefit payments are based on your average weekly wages for the eight weeks immediately prior to your disability, and are subject to the maximum allowable by the law in effect on the initial day of disability. Your employer or union may provide for different benefits which are at least as favorable as statutory benefits under an approved Disability Benefits Plan or Agreement.
3. TO CLAIM BENEFITS you should file written notice and proof of disability (Claim Form DB-450) with your employer or the insurance carrier named below within 30 days from the first day of your disability, or all or part of your claim may be rejected. In no event should you wait more than 26 weeks from that date to file a claim. You may obtain Form DB-450 from your employer, its insurance carrier, your health care provider or by contacting the Workers' Compensation Board. (See address and telephone number below.) **Do not** assume that your employer has filed a claim on your behalf; **claim filing is your responsibility.**
4. You are entitled to be treated by any physician, chiropractor, dentist, nurse-midwife, podiatrist or psychologist of your choice. Unlike workers' compensation, your medical bills will **not** be paid by your employer or the insurance carrier, unless your employer and/or union provides for the payment of medical bills under an approved Disability Benefits Plan or Agreement.
5. Disability Benefits are to be paid **directly** to you by the insurance carrier, **not through your employer**, unless your employer is an approved self-insurer.
6. **If your employer or the insurance carrier contends that you are not entitled to the payment of Disability Benefits, they are required to send you a Notice of Rejection, within 45 days of the filing of your claim, telling you the reasons benefits are not being paid. If you disagree with their rejection, you have a legal right** to request a review of the rejection by the Workers' Compensation Board. **IMPORTANT:** If within 45 days of filing your claim you do not receive benefits and do not receive a Notice of Rejection (Form DB-451), promptly contact the Workers' Compensation Board at the telephone number below.
7. **If your disability is the result of an automobile accident** and you have filed a claim for no-fault benefits, you must also file a claim (Form DB-450) for disability benefits. **If you do not file for disability benefits, the no-fault insurer may reduce your no-fault payments. IMPORTANT**: In such cases, if you are not entitled to disability benefits, immediately advise the no-fault insurance carrier.
8. Your employer may not ask you to waive your right to disability benefits nor may your employer deduct more than 60 cents a week (unless the additional contribution is part of an approved plan) from your pay to contribute to the payment of disability benefits insurance premiums. **You cannot be discharged or discriminated against for filing a claim for disability benefits.**

**IF YOU HAVE DIFFICULTY IN OBTAINING A CLAIM FORM OR NEED HELP IN FILLING IT OUT, OR IF YOU HAVE ANY OTHER QUESTIONS OR PROBLEMS ABOUT A NON-WORK RELATED INJURY OR ILLNESS, CONTACT ANY OFFICE OF THE WORKERS' COMPENSATION BOARD.**

This information is a simplified presentation of your rights as required by Section 229 of the Disability Benefits Law. Your employer's disability benefits insurance carrier is:

Dearborn National Life Insurance Company of New York
Administrative Office - 85 Allen Street, Suite 210
Rochester NY 14608

ROBERT E. BELOTEN
CHAIR

**NYS Workers' Compensation Board, Centralized Mailing, PO Box 5205, Binghamton, NY 13902-5205**

**Customer Service Toll-Free Line: 877-632-4996**

DB-271S (1-11)

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.
ESTE RESUMEN ESTA ESCRITO EN ESPANOL AL DORSO.

www.wcb.ny.gov

Form DB-271

**For employees with an off-duty injury or illness, provide Claim Form DB-450 as well as Form DB-271. On Claim Form DB-450, employee completes Part A, employee health care provider completes Part B, City Human Resources completes Part C**
**Completed form is sent by HR to Karen Rulfs @ First Niagara Benefits**

# INSTRUCTIONS FOR COMPLETING DB-450 DISABILITY CLAIM FORM

Dearborn National®
Life Insurance Company of New York

**NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS**

***Claimant: Read the following Instructions Carefully***

1. Use this form only if you become sick or disabled **while employed** or if you become sick or disabled **within four (4) weeks after termination of employment.** Use **green** 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-"**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 - "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***

1. Name (first/middle/last) | 2. Social Security Number

3. Address (no./street/apt./city/state/zip code)

4. Telephone No. | 5. Age | 6. Married (check one) ❒ Yes ❒ No

7. My disability is (if injury, also state **how, when** and **where** it occurred)

8. Date Disabled (month/day/year) | a. I worked on the last day ❒ Yes ❒ No | b. I have since worked for wages or profit ❒ Yes ❒ No If Yes, give dates:

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

| Employer's Name | Employer's Business Address | Telephone No. | Dates of Employment From (mo/day/yr) | Through (mo/day/yr) | Average Weekly Wages include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc. |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

10. Occupation (describe job) | a. Name of Union and Local No., if Member

11. For the period of disability covered by this claim | Yes | No
    a. Are you **receiving** wages, salary or separation pay ❒ ❒
    b. Are you **receiving or claiming:**
    (1) Workers' Compensation for work-connected disability ❒ ❒
    (2) Unemployment Insurance Benefits ❒ ❒
    (3) Damages for personal injury ❒ ❒
    (4) Benefits under the Federal Social Security Act for long term disability ❒ ❒
    c. IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 11a or 11b, COMPLETE THE FOLLOWING:
    If have ❒ received ❒ claimed from _____ for the period _____ (Date) to _____ (Date)

12. 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)

13. 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.

**Sign Here** _____ (Date Signed) _____ (Claimant's Signature)

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

_____ (Name and Address) _____ (Relationship)

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

Si Se le ocurren algunas preguntas respecto a reclamar beneficios por incapacidad, comuníquese con su 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

**Health Care Provider must complete part B on reverse**

Any person who knowingly and with intent to defraud any insurance company files a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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PART A TO BE COMPLETED BY EMPLOYEE

Dearborn National®
Life Insurance Company of New York

**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 green claim form DB-300.

***Part B - Health Care Provider's (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 7-d, 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 _____ (First Middle Last) 2. Age _____ 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 consecutive, please enter estimate date. Please use such as unknown, or not determined.)

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/C-48 been filed with the Workers' Compensation Board? ❒ Yes ❒ No
   Remarks (Attach additional sheet if necessary):
   **If disability is pregnancy related, please enter estimated delivery date**

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

Health Care Provider's Signature _____ Date _____

Health Care Provider's Name (Please Print) _____ Telephone # _____

Office Address _____ (Number Street) _____ (City or Town) _____ (State) _____ (Zip Code)

PART B TO BE COMPLETED BY PHYSICIAN

***Part C - Employer's Statement***

***IMPORTANT - Indicate percentage Employee contributes to premium _____%***
***(If blank or not a % we will tax at 100%)***

1. Employee's Name | 2. Employee's Address

3. Employee's Occupation | 4. Date Employed | 5. Social Security No. | 6. Policy No.

7. ❒ Full time ❒ Part time Check usual days worked: ❒ Mon ❒ Tues ❒ Wed ❒ Thur ❒ Fri ❒ Sat ❒ Sun

8. Is claimant an ❒ Employee ❒ Owner ❒ Partner ❒ High school student | 9. Date employee last worked

10. Date employee's wages ceased | 11. Date employee returned to work | 12. Is wages being continued during disability? ❒ Yes ❒ No | 13. If yes, is reimbursement requested? ❒ Yes ❒ No

14. Date you received the completed claim form | 15. Did the disability occur as a result of employment? ❒ Yes ❒ No

16. Name and address of your Workers' Compensation carrier

17. Do you expect to recover? ❒ Yes ❒ No | 18. Is employee a member of a union that provides state disability benefits? ❒ Yes ❒ No

19. If employee no longer in your employ, check reason: ❒ Labor dispute ❒ Lack of work ❒ Fired ❒ Quit ❒ Retirement

20. Has the claimant received U.I. benefits? ❒ Yes ❒ No If yes, give dates.

| EARNINGS FOR 8 WEEKS PRIOR TO DISABILITY (Including the week in which the disability began) | | | | |
|---|---|---|---|---|
| MONTH | DAY | YEAR | NO. DAYS WORKED | AMOUNT |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | TOTAL | |

_____ Name of Employer _____ Policy No.
_____ Address
_____ Signature of Employer _____ Title
Phone No. _____ Dated _____, 20____

Indicate weekly value of board, lodging and tips
$_____

**Claims Inquiry only - (800) 421-3711 • Dearborn National® Life Insurance Company of New York • Administrative Office: 85 Allen Street, Suite 210 • Rochester, NY 14608**

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PART C TO BE COMPLETED BY HUMAN RESOURCES

**INSTRUCTIONS FOR FILING DB-450 CLAIM FORM** For Claim Form DB-450, employee completes Part A. Then, employee's health care provider completes Part B, Lastly, City Human Resources completes Part C. Completed form is then sent by HR to Karen Rulfs @ First Niagara Benefits who files with Dearborn National. *Note: only physicians, chiropractors, psychologists, dentists, podiatrists, and nurse-midwives can sign Part B, not nurses or physician's assistants.*

# FREQUENTLY ASKED QUESTIONS

## SHORT-TERM DISABILITY

**What is short-term disability?**

Disability Benefits are temporary cash benefits payable to an eligible wage earner who is disabled ban off the job injury or illness.

**Who is eligible for short-term disability payments?**

You are eligible if you are working or have recently worked for a covered employer for at least four consecutive weeks. City of Plattsburgh is a covered employer.

**What is the short-term disability benefit?**

Benefits are 50% of your average weekly wage (AWW) based on your last eight weeks of employment, not counting the week in which your disability began, if its inclusion would lower your benefit rate up to a maximum benefit of $170/week.

**How long are the benefits payable?**

Benefits are payable for a maximum 26 weeks of disability during 52 consecutive weeks.

**Is there a waiting period?**

The first seven (7) days of disability are a waiting period for which no benefits are paid. Benefits begin on the eighth consecutive day of disability.

**How do I file a short-term disability claim?**

If you are disabled for longer than 7 days, your employer will provide you with a Statement of Rights under the Disability Benefits Law (Form DB-271) and a claims form (DB-450) within five days of your employer's knowledge that you are disabled.

**How long do I have to file a disability claim?**

You should file your claim within 30 days after you become disabled. Claims filed late are not necessarily rejected, but you will not be paid for any disability period more than two weeks before the claim was filed unless you can show that it was not reasonable possible to file earlier. You will not receive any benefits if your claim is filed more than 26 weeks after your disability began.

**When will I receive the first payment?**

If your claim is properly completed, you should receive the first payment within four business days after the 14th day of disability, or four business days after receipt of your claim, whichever is later. Further benefits are payable every two weeks provided there is medical documentation to substantiate the disability.

**Will there be supplemental medical reports required throughout the entire period of disability?**

There will be supplemental medical reports that must be submitted throughout the entire period of disability. Failure to return these reports may result in the suspension of benefits.

**Do I have to explain how I was hurt, if the disability is a result of an injury?**

Yes, if the disability results from an injury, the claimant must explain how, when, and where the injury occurred on the DB-450 Form.

**What part of the DB-450 do I complete?**

Employee completes Part A, health care provider completes part B and Human Resources completes part C.

**What if my injury is work-related and my WC claim is controverted, can I then apply for short-term disability?**

If the injury is work-related and the WC claim is controverted by the employer, the employer must include a copy of Form C-7 (Notice of Compensation is Controverted).

**Is my short-term disability benefit taxable?**

If you contribute towards the cost of disability insurance, your benefit may <u>not</u> be fully taxable.

**What happens if my claim is rejected?**

If your claim is rejected, you have a right to ask the Workers' Compensation Board for a review.

**Who governs my eligibility for Disability Benefits?**

Your eligibility for Disability Benefits is governed by the NY Disability Benefits Law.

**Who is the current short-term disability insurer for City of Plattsburgh?**

Dearborn National Life Insurance Company of New York
New York Disability Claim Office
85 Allen Street, Suite 201
Rochester, NY 14608
(800) 421-3711