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Claims Guide | New York — *ShelterPoint Life*

How to Complete the DBL Claim Packet

A guide for the Claimant, Healthcare Provider, & Employer

What is the DB450 Claim Form?

The DB450 Claim Form is the initial form used to file a disability benefits claim for individuals who become disabled due to a non work-related illness or injury while employed. The same form is also used within 4 weeks after termination of employment OR if you become disabled after having been unemployed for more than 4 weeks.

To ensure your claim is handled in a timely fashion, it is important that this claim form is legibly filled out in its entirety with all sections completed. **Missing, incomplete, or illegible information will result in a delay in processing your claim.**

Before submitting this Claim Form for processing, be sure each section is **fully completed**. With all sections signed and dated by the required parties. There are 3 sections on the DB450:

- **Part A** **Claimant's Information** is for the **Claimant (Employee)**
- **Part B** **Healthcare Provider's Statement** is for the **treating Physician/Medical Practitioner**
- **Part C** **Employer's Statement** is for the **Employer**

Each Part must be fully completed, include supplemental forms signed, and dated by the appropriate party.

Be sure to make a copy of the completed Claim Form and retain for your records. A detailed outline of each section is below.

Your privacy and security is important to us - none of your information is distributed to 3rd parties without your express consent.

In this section you will enter your First and Last Name, Social Security Number, Mailing Address and other details which will aid in processing the claim.

All information should be printed & legible.

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Part A Claimant's Information

New York State
NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS
Claim Number: ________________

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

1. Last Name: ______________________ First Name: ______________________ MI: __
2. Mailing Address (Street & Apt. #): ______________________
   City: ______________ State: _____ Zip: __________
3. Daytime Phone #: ______________ (Area Code + Phone Number) Email Address: ______________________

ShelterPoint Disclaimer: By providing your contact information you consent to Us contacting you by any of the methods provided.

4. Social Security #:_______-______-_________ 5. Date of Birth:_____/_____/_______ 6. Gender: ☐ M ☐ F ☐ X
7. Describe your disability (if injury, also state how, when and where it occurred): ______________________
8. Date you became disabled:_____/______/_________ Did you work on that day?: ☐ Yes ☐ No

   Have you recovered from this disability?: ☐ Yes ☐ No If Yes, date you were able to return to work:_____/_____/_________

   Have you since worked for wages or profit?: ☐ Yes ☐ No If Yes, list dates: ______________________

9. Name of last employer prior to disability. If more than one employer in previous eight (8) weeks, name all employers. Average Weekly Wage is based on all wages earned in last eight (8) weeks worked.

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

Part A on page 1 of 4

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

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

10. My job is or was: ______________________ (Occupation) 11. Union Member: ☐ Yes ☐ No If "Yes": ______________ (Name of Union or Local Number)

12. Were you claiming or receiving unemployment prior to this disability? ☐ Yes ☐ No
    If you did **not** claim or if you claimed but did **not** receive unemployment insurance benefits *after* LAST DAY WORKED, explain reasons fully: ______________________

    If you did receive unemployment benefits, provide all periods collected: ______________________

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Part A Claimant's Information

Claim Number: ____________

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

13. For the period of disability covered by this claim:
    A. Are you receiving wages, salary or separation pay? ☐ Yes ☐ No
    B. Are you receiving or claiming:
        1. Unemployment Benefits? ☐ Yes ☐ No 2. Paid Family Leave? ☐ Yes ☐ No
        3. Workers' compensation for work-connected disability? ☐ Yes ☐ No
        4. No-Fault motor vehicle accident? ☐ Yes ☐ No **or** personal injury involving third party? ☐ Yes ☐ No
        5. Long-term disability benefits under the Federal Social Security Act for *this* disability? ☐ Yes ☐ No

IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 13, COMPLETE THE FOLLOWING:
I have: ☐ received ☐ claimed from: ____________ for the period: ___ / ___ / ___ to: ___ / ___ / ___

14. In the year (52 weeks) before your disability began, have you received disability benefits for other periods of disability? ☐ Yes ☐ No
    If yes, Paid by: ____________ from: ___ / ___ / ___ to: ___ / ___ / ___
15. In the year (52 weeks) before your disability began, have you received Paid Family Leave? ☐ Yes ☐ No
    If yes, Paid by: ____________ from: ___ / ___ / ___ to: ___ / ___ / ___
16. If you became disabled while employed or within four weeks of your last day worked, did your employer provide you with your rights under Disability Law within 5 days of your notice or request for disability forms? ☐ Yes ☐ No

I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled. I have read the instructions of this form and certify that the foregoing statements, including any accompanying statements are, to the best of my knowledge, true and complete.

Claimant's Signature **Date**

An individual may sign on behalf of the claimant only if they are legally authorized to do so and the claimant is a minor, mentally incompetent or incapacitated. If signed by other than claimant, print information below and complete and submit Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records.

On behalf of Claimant **Address** **Relationship to Claimant**

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

THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY. THE ATTENDING HEALTH CARE PROVIDER SHALL COMPLETE AND RETURN TO THE CLAIMANT WITHIN SEVEN (7) DAYS OF RECEIPT OF THIS FORM. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date in item 7-e. **INCOMPLETE ANSWERS MAY DELAY PAYMENT OF BENEFITS.**

1. Last Name: ____________ First Name: ____________ MI: ___
2. Gender: ☐ M ☐ F ☐ X 3. Date of Birth: ___ / ___ / ___
4. Diagnosis/Analysis: ____________ Diagnosis Code: ____________
    a. Claimant's symptoms: ____________
    b. Objective findings: ____________
5. Claimant hospitalized?: ☐ Yes ☐ No From: ___ / ___ / ___ To: ___ / ___ / ___
6. Operation indicated?: ☐ Yes ☐ No a. Type ____________ b. Date ___ / ___ / ___

7. ENTER DATES FOR THE FOLLOWING	MONTH	DAY	YEAR
a Date of your first treatment for this disability			
b. Date of your most recent treatment for this disability			
c. Date Claimant was unable to work because of this disability			
d. Date Claimant will again be able to perform work (Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)			
e. If pregnancy related, please check box and enter the date ☐ estimated delivery date OR ☐ actual delivery date			

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease?: ☐ Yes ☐ No If "Yes", has medical been filed with the Board? ☐ Yes ☐ No

I certify that I am a:

(Physician, Chiropractor, Dentist, Podiatrist, Psychologist, Nurse-Midwife) **Licensed or Certified in the State of** **License Number**

Health Care Provider's Printed Name **Health Care Provider's Signature** **Date**

Health Care Provider's Address **Phone #**

Part A continues on top of page 2 of 4

Part A Claimant's Information

Question 1:
PRINT your last name and first name in the space provided.

Question 2:
PRINT your current mailing address (Street name, apartment #, City, State, Zip). We will use the address provided when mailing correspondence and/or benefit checks to you. An incomplete or incorrect address could result in returned or lost mail and delay in processing your claim.

Question 3 – Daytime Phone # and email address:
This is the contact phone and email address where we may reach you, should there be any questions on your claim.

Question 4 – Social Security #:
Enter your nine digit social security number in the boxes provided. This information is required for tax reporting purposes. If you have an I-TIN instead of a SSN; provide your I-TIN.

Question 5 – Date of Birth:
Enter the month, day, and year in which you were born.

Question 6 – Gender:
Select your gender. Indicate M for male, F for female, or X for non-binary.

Question 7:
Enter a brief description of your disability. If you were injured, please also provide details on when (date) and where (location of incident) the incident occurred, as well as how you came to be injured.

Question 8:
Enter the date you became disabled, whether or not you worked on that day, whether you have recovered from this disability (and if so, the date you were able to work), and if you have since worked for wages. If you have since worked for wages, provide dates.

Question 9:
Enter your **Employer's information**, including business name, address, phone #, dates employed (when you started working through your last day worked prior to the disability) and within each of the eight boxes, your last day worked, the number of days worked that week, as well as the gross amount earned.

IMPORTANT: If you have more than one job, be sure to complete the 8 week grid for each of your employers, attach a separate copy if necessary. Alternatively; you may include copies of paystubs with your submission for ALL employers. Each employer will need to complete their own Part C.

Question 10:
Tell us your job title.

Part A Claimant's Information

Question 11:
Please indicate if you are a member of a union that **provides statutory NY DBL benefits**. If yes, provide the union name and number.

Note - If you are a member of a union that provides supplemental/fringe benefits (not statutorily mandated) do not check "YES".

Question 12:
Indicate whether you are claiming or receiving unemployment benefits prior to this disability: (Check Yes or No where applicable). If you didn't claim or if you claimed but didn't receive unemployment benefits after your last day worked, provide detail in the space provided.

Question 13 – For the period of disability covered by this claim:

a) Have you received any wages, salary, or separation pay? If so, enter YES, and specify in which you are receiving or have made a claim for these benefits. If your wages have ceased, enter NO.

b) Are you receiving or claiming: (Check Yes or No where applicable)
   (1) Unemployment
   (2) Paid Family Leave
   (3) Workers Comp
   (4) No-Fault or Personal Injury Involving Third Party.
   (5) Long-term disability

*If you have marked YES to any of the options in question 13, you must also provide additional detail regarding the period of time in which you are receiving or claiming these benefits. *

Question 14:
Answer Yes or No to the question "in the year (52 weeks) **before** your disability began, have you received disability benefits for other periods of disability?". If yes, provide from whom the benefit was collected, and the period of time during which you received benefits.

Question 15:
Answer Yes or No to the question "in the year (52 weeks) **before** your disability began, have you received Paid Family Leave". If yes, provide from whom the benefit was collected, and the period of time during which you received benefits.

Question 16:
Answer Yes or No to the question "if you became disabled while employed or within four weeks of your last day worked, did your employer provide you with your rights under Disability law within 5 days of your notice or request for disability forms?"

Part A must be signed by claimant and/or authorized representative.

End of Part A.

Part B Healthcare Provider's Statement

Instructions for the Claimant:

This section must be completed by your treating Healthcare provider or Practitioner, providing all details of your disabling condition. Be sure all questions are answered, the information is legible, and your provider/practitioner has signed and dated Part B. This section must be completed, signed and dated **AFTER** the date you became disabled and stopped working.

Be sure your form is completed and signed by an authorized practitioner.

Please be advised **the following medical professionals are NOT authorized** to complete and sign part B of the DB450 form:

- RN (Registered Nurse)
- CSW (Certified Social Worker)
- PT (Physical Therapist)
- LPN (Licensed Practical Nurse)

Instructions for the Health Care Provider:

IMPORTANT: Part B must be fully and legibly completed to process the claim in a timely fashion. In addition to providing the medical details necessary to examine the claim, **this statement MUST be signed by the treating practitioner and dated to be considered acceptable.**

You must select the appropriate professional degree, enter your license number and state in which you are licensed to practice. Finally, we must have your practice name and mailing address in case additional medical documentation is required.

Note - Failure to provide dates, or using terms such as "TBD" or "indefinite" may delay processing of the claim. Please use the best medical estimate, and provide actual dates.

Part B Healthcare Provider's Statement

Claim Number: ____________________

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

13. For the period of disability covered by this claim:
    A. Are you receiving wages, salary or separation pay? ☐ Yes ☐ No
    B. Are you receiving or claiming:
        1. Unemployment Benefits? ☐ Yes ☐ No 2. Paid Family Leave? ☐ Yes ☐ No
        3. Workers' compensation for work-connected disability? ☐ Yes ☐ No
        4. No-Fault motor vehicle accident? ☐ Yes ☐ No **or** personal injury involving third party? ☐ Yes ☐ No
        5. Long-term disability benefits under the Federal Social Security Act for *this* disability? ☐ Yes ☐ No

IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 13, COMPLETE THE FOLLOWING:
I have: ☐ received ☐ claimed from: ____________ for the period: ___ / ___ / _____ to: ___ / ___ / _____

14. In the year (52 weeks) before your disability began, have you received disability benefits for other periods of disability? ☐ Yes ☐ No
    If yes, Paid by: ____________ from: ___ / ___ / _____ to: ___ / ___ / _____

15. In the year (52 weeks) before your disability began, have you received Paid Family Leave? ☐ Yes ☐ No
    If yes, Paid by: ____________ from: ___ / ___ / _____ to: ___ / ___ / _____

16. If you became disabled while employed or within four weeks of your last day worked, did your employer provide you with your rights under Disability Law within 5 days of your notice or request for disability forms? ☐ Yes ☐ No

Part B on bottom of page 2 of 4

I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled. I have read the instructions of this form and certify that the foregoing statements, including any accompanying statements are, to the best of my knowledge, true and complete.

Claimant's Signature ____________ Date ____________

An individual may sign on behalf of the claimant only if they are legally authorized to do so and the claimant is a minor, mentally incompetent or incapacitated. If signed by other than claimant, print information below and complete and submit Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records.

On behalf of Claimant ____________ Address ____________ Relationship to Claimant ____________

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

THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY. THE ATTENDING HEALTH CARE PROVIDER SHALL COMPLETE AND RETURN TO THE CLAIMANT WITHIN SEVEN (7) DAYS OF RECEIPT OF THIS FORM. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date in item 7-e. **INCOMPLETE ANSWERS MAY DELAY PAYMENT OF BENEFITS**.

1. Last Name: ____________ First Name: ____________ MI: ___
2. Gender: ☐ M ☐ F ☐ X 3. Date of Birth: ___ / ___ / _____
4. Diagnosis/Analysis: ____________ Diagnosis Code: ____________
    a. Claimant's symptoms: ____________
    b. Objective findings: ____________
5. Claimant hospitalized?: ☐ Yes ☐ No From: ___ / ___ / _____ To: ___ / ___ / _____
6. Operation indicated?: ☐ Yes ☐ No a. Type ____________ b. Date ___ / ___ / _____

7. ENTER DATES FOR THE FOLLOWING	MONTH	DAY	YEAR
a Date of your first treatment for this disability			
b. Date of your most recent treatment for this disability			
c. Date Claimant was unable to work because of this disability			
d. Date Claimant will again be able to perform work (Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)			
e. If pregnancy related, please check box and enter the date ☐ estimated delivery date OR ☐ actual delivery date			

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease?:
    ☐ Yes ☐ No If "Yes", has medical been filed with the Board? ☐ Yes ☐ No

I certify that I am a:

(Physician, Chiropractor, Dentist, Podiatrist, Psychologist, Nurse-Midwife) ____________ **Licensed or Certified in the State of** ____________ **License Number** ____________

Health Care Provider's Printed Name ____________ **Health Care Provider's Signature** ____________ **Date** ____________

Health Care Provider's Address ____________ **Phone #** ____________

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Part B Healthcare Provider's Statement

All information should be printed & legible. Incomplete answers may delay payment of benefits.

Question 1:
PRINT the claimant's (Patient) Last Name and First Name.

Question 2– Gender:
Select the claimant's gender. Please indicate M for male, F for female, or X for non-binary.

Question 3–Date of Birth:
Enter the claimant's date of birth (month, day, year).

Question 4– Diagnosis/Analysis:
Indicate the symptoms and objective findings of the claimant's disabling condition. Be sure to include any complications which may have exacerbated the disabling condition and provide applicable diagnosis codes if possible.

For pregnancy/childbirth, regulations permit the claimant to stop working 4 weeks prior to the due date, including 6 weeks of benefits after a natural delivery, and 8 weeks of benefits after a c-section (with no complications).

If the claimant has any ante or post-partum complications that may extend this timeframe, you must provide detail here.

Question 5:
Indicate if the claimant was hospitalized. If hospitalized, provide the confinement dates (from/to).

Question 6:
Indicate whether or not an operation was performed. If yes, provide type of surgery and the date it took place.

Question 7:

IMPORTANT: YOU MUST PROVIDE DATES for questions 7A through 7D.

a) Date of claimant's **FIRST (Initial)** treatment for their disability (print date in Month, Day, Year format in the boxes provided).
b) Date of claimant's **MOST RECENT** treatment for their disability (print date in Month, Day, Year format in the boxes provided).
c) Date claimant was medically **UNABLE TO WORK (ONSET DATE)** due to this disability (print date in Month, Day, Year format in the boxes provided). This is not necessarily a working day, but the actual day that you certified the claimant disabled.
d) Date claimant will be again be able to perform work **(PROGNOSIS)** (print date in Month, Day, Year format in the boxes provided). **DO NOT LEAVE THIS FIELD BLANK OR ENTER "TBD/ UNDETERMINED".** You may estimate a prognosis date based on the claimant's current condition and taking into consideration all applicable diagnoses. If claimant will never be able to work again due to their disability, please specify.
e) If pregnancy related, please check box (estimated delivery date or actual delivery date) and enter the date.

Part B Healthcare Provider's Statement

Question 8:
Indicate whether or not this disabling condition may be WORK RELATED.
If Yes, indicate whether a medical report has been filed with the Workers' Compensation Board.

Practitioner Information (Type of Practitioner, License State, License #, Signature, Date, Practice Name, Mailing address etc). **Sign and date the form, make a copy for your records, and return to the claimant.**

End of Part B.

Part C Employer's Statement

Instructions For the Claimant:

In this section **your employer** will provide details of your employment. Be sure all questions are answered, the information is legible, and your employer has signed and dated Part C.

If you have more than 1 employer, be sure **each** employer completes their own Part C, and all pages are included with your claim submission.

If you are self-employed, your bookkeeper or accountant must complete this form on your behalf. You may be asked to provide copies of your K-1 or 1040 schedule C.

Instructions For the Employer:

Part C must be **fully and legibly** completed to process the claim in a timely fashion. In addition to providing the employee's details of their employment necessary to examine the claim, **this statement MUST be signed, titled, and dated to be considered acceptable**. We must also have your business name and mailing address in case additional information is required.

Part C Employer's Statement

Policy #:________________ Claim Number: ________________

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

1. Business's full legal name and mailing address

Business Name ____________________

Mailing Address ____________________

City, State, Zip Code ____________________

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

2. Employer's FEIN: ______-____________________

3. Contact Information:

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

Employer's contact telephone number: ____________________
Area Code + Phone Number

Employer's contact email address: ____________________

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

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

____

5. Employee Information:

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

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

Date employee last worked: ____________________

Date employee returned to work (if applicable): ____________________

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

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

Part C on page 3 of 4

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

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

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

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

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

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

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

Disability: Please provide specific dates for disability ____________________

PFL: Please provide specific dates for PFL ____________________

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

If no, date employment was terminated: ____________________

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

Part C Employer's Statement

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

Employer Name and Title: ______________________________

Employer Signature: ______________________________

Employer Contact Phone Number: ______________________________
Area Code + Phone Number

Date: ______________________________

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 552a). The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law

HIPAA NOTICE - In order to adjudicate a workers' compensation claim or disability benefits claim, WCL 13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the insurance carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

Disclosure of Information: The Board will not disclose any information about your case to any unauthorized party without your consent. If you choose to have such information disclosed to an unauthorized party, you must file with the Board an original signed Form OC-110A "Claimants Authorization to Disclose Workers' Compensation Records." This form is available on the WCB website (www.wcb.ny.gov) and can be accessed by clicking the "Forms" link. If you do not have access to the internet please call (877) 632-4996. In lieu of Form OC-110A, you may also submit an original signed, notarized authorization letter.

FRAUD ACKNOWLEDGEMENT *- An employer or insurer, or any employee, agent, or person acting on behalf of an employer or insurer, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.*

Retain a copy of the form for your records and return fully completed claim forms to ShelterPoint by one of the below listed methods:

Fax: 516-504-6414
Mail: ShelterPoint Life, Attn: Claims Dept, 1225 Franklin Ave – Ste 475, Garden City NY 11530
Email: claimforms@shelterpoint.com
Web upload: www.shelterpoint.com

If submitting updates on an existing claim, please include the **claim number** and **claimant first and last name** in the subject line.
For questions regarding claims, including status updates- contact our customer service department at 1-800-365-4999 Monday – Friday during normal business hours .
For copies of claim packages – visit our claims help page at https://info.shelterpoint.com/claim-help

Part C continues on page 4 of 4

Part C Employer's Statement

PLEASE NOTE:

Part C cannot be completed or signed by the claimant. If you (the claimant) are the owner/proprietor, the employer's statement must be completed and signed by a bookkeeper or accountant, and additional support of wages may be requested (ex. 1040 Schedule C, K-1, W-2, or paystubs).

Please provide your ShelterPoint policy number. If providing an update to an existing claim, please also provide the claim number.

Question 1:
Provide the business' full legal name and mailing address, including city, state, zip code, and country (if not USA).

Question 2:
Provide the employer's nine-digit Federal Employer Identification Number (FEIN).

Question 3:
Provide the employer's contact information regarding the claim; including name, phone number, and email address.

Question 4:
Indicate if the employee is a member of a union that provides statutory NY DBL benefits (respond with Yes or No). If yes, provide the Union Name and Number.

Note - If the employee is a member of a union, that provides supplemental/fringe benefits (not statutorily mandated) do not check "YES".

Question 5:
Provide details related to the employee's employment:

- The employee's role (employee, proprietor, partner, spouse of employer, owner, or co-owner.)
- Date of hire
- The date the employee last worked
- Date the employee returned to work (if applicable)

Question 6:
Indicate if wages were continued during disability (Respond with YES or NO). Note, if wages were continued, we will need to know the type of wages (Sick Time, Vacation Time, PTO) and dates collected. You can provide a breakdown on a separate piece of paper to be submitted at same time.
If wages were continued, please indicate if reimbursement to the employer is requested.

Question 7:
Indicate if the employee's disability is work related (respond with Yes or No).

Part C Employer's Statement

Question 8- Wages Grid:
Provide the employee's 8 weeks of GROSS (pre-tax) wages immediately prior to becoming disabled, including the number of days worked.

You may also submit the same information as a separate page. NOTE: If payroll is bi-weekly, only 4 pay periods should be listed.

If this employee receives additional remuneration in the form of bonuses, tips, board, lodging, or rent, include the average weekly amount in the reported wages.

Question 9:
Indicate whether the employee has received or claimed Disability Benefits and/or Paid Family Leave benefits within the past 52 weeks. If yes, please provide the dates for each claim.

Question 10:
Indicate if the employee is still employed by you. If not, enter the date employment was terminated.

If the reason for termination is a disqualifying reason under unemployment insurance laws, please provide this detail to us.

Question 11:
Enter the last date the employee received unemployment benefits, if applicable.

Additional Required Info on Part C:

- Employer name and title
- Employer signature
- Employer contact phone number
- Date the form was completed and signed

End of Part C.

Once the DB450 form is fully completed, make a copy for your records, and submit one copy to ShelterPoint for processing. The completed claim should be mailed within 30 days of becoming disabled.

Disability Benefits Claims Division:
Email: claimforms@shelterpoint.com
Fax: 516-504-6414
Mail: ShelterPoint Life, 1225 Franklin Ave, Ste 475, Garden City, NY 11530.

Questions?
customerservice@shelterpoint.com or 800.365.4999

Supplement to DB450 Claim Form

Supplement to DB450 – Notice and Proof of Claim for Disability Benefits – NY

Claim Number: ___________________

Overview & Instructions:

This supplemental form is used to obtain additional information from both the Claimant and Employer that were not included on the prescribed DB450 form, but may be required as part of state or federal regulation. Part 1 is for the claimant to complete, to indicate their benefit payment preference. Part 2 is for the Employer to complete, to provide details that will aid in determining the taxation of benefit payments.

Part 1: COMPLETED BY THE CLAIMANT/EMPLOYEE REQUESTING NY DISABILITY BENEFITS

Claimant Last Name:________________________________ Claimant First Name:__________________________

SSN/I-Tin: __ __ __ - __ __ - __ __ __ __ Date of Birth: ____ /____ /_______

Benefit Payment Preference for eligible ShelterPoint Disability Claims

Please choose your preference for receiving benefit payments. Certain options may not be available depending on the benefit recipient. If your claim does not qualify for ACH/direct deposit, your benefit payments will automatically be issued via paper check. A completed enrollment form is required to participate in direct deposit. Proof of banking/Account information is needed to establish Direct Deposit (e.g. copy of voided check or letter from bank confirming accountholder name, routing number and account number).

☐ **Paper Check** ☐ **Direct Deposit (ACH)**

Claimant Signature: ______________________ Date signed: ____ /____ /_______

SPL - DB450 Supplement Form

Part 2: COMPLETED BY THE EMPLOYER (ER) FOR THE EMPLOYEE REQUESTING NY DISABILITY BENEFITS.

Employer Name (Business Name): ____

Employer FEIN: __ __ - __ __ __ __ __ __ __ ShelterPoint DBL Policy #: _________________

Contributions to Disability Benefit Premiums

Does employee contribute to the costs of state-mandated disability premium?

☐ Yes → dollar amount per week $________ *or* percentage of contribution _________%

☐ No

Important note: Employee contributions to state-mandated disability benefits may appear on the employee's pay stub as "SDI" or "NY DBL" contribution. The maximum employee contribution for NY DBL is currently set at 0.5% of wages up to a maximum of $0.60 per week. This is a *separate contribution* amount than NY PFL. Please check against payroll records to ensure you are accurately reporting the contribution status and details for employees as it can have tax implications.

If the employee is fully paying the costs to the disability benefits premium, then the employee contributes 100%, and the claim should be non-taxable. If the employee does not contribute, then their claim would be 100% taxable. If the employee contributes a portion to disability benefits premium, then their claim would be partially taxable based on the ratio of employee to employer contributions. **If you leave this section blank we will assume the employee <u>does not</u> contribute.**

Employer Name & Title: ____

Employer Contact Email: ____

Employer Contact Phone #:(_______)____

Employer Signature:____________________________________ Date Signed: ____ /____ /_______

End of DB450 Supplement

SPL - DB450 SUPPLEMENT (NY) 3/2024

Supplement to DB450 Claim Form

This supplemental form is used to obtain additional information from both the Claimant and Employer that were not included on the prescribed DB450 form, but may be required as part of state or federal regulation.

Part 1: is for the claimant to complete, to indicate their benefit payment preference.

Claim Number
Enter the claim number at the top right of the form, if known.

Last Name
Enter your last name.

First Name
Enter your first name.

SSN/I-Tin
Enter your nine-digit social security number in the boxes provided. This information is required for tax reporting purposes. If you have an I-TIN instead of a SSN; provide your I-TIN.

Date of Birth
Enter the month, day, and year in which you were born.

Benefit Payment Preference:
Choose your preference for receiving benefit payments. ACH/Direct deposit not available if the benefit recipient is the employer. If your claim does not qualify for ACH/direct deposit, your benefit payments will automatically be issued via paper check.

A completed enrollment form is required to participate in direct deposit. Proof of banking/Account information is needed to establish Direct Deposit (e.g. copy of voided check or letter from bank confirming accountholder name, routing number and account number).

Claimant Signature/ Date Signed
Sign and date once this section is fully completed.

(See the dedicated section on the Direct Deposit Enrollment Form for further instructions)

Supplement to DB450 Claim Form

Part 2: is for the Employer to complete, to provide details that will aid in determining the taxation of benefit payments.

Employee contributions to state-mandated disability benefits may appear on the employee's pay stub as "SDI" or "NY DBL" contribution. The maximum employee contribution for NY DBL is currently set at 0.5% of wages (up to a maximum of $0.60 per week).

This is a separate contribution amount than NY PFL. Check against payroll records to ensure accuracy in reporting the contribution status and details for employees as it can have tax implications.

- If the employee is fully paying the costs to the disability benefits premium, then the employee contributes 100%, and the claim should be non-taxable.
- If the employee does not contribute, then their claim would be 100% taxable.
- If the employee contributes a portion to disability benefits premium, then their claim would be partially taxable based on the ratio of employee to employer contributions.

ShelterPoint does not provide tax advice, please consult with a tax professional.

Employer Name (Business Name)
Enter the name of the employer/business.

Employer FEIN
Enter the nine-digit Federal Employer Identification Number.

ShelterPoint DBL Policy #
Enter the employer's ShelterPoint policy number.

Does the Employee Contribute to the Costs of State Mandated Disability Premium?
Select Yes, and include the amount either in dollars or as a percentage of their earnings each week. If the employee does not contribute, enter No. If you leave this section blank we will assume the employee does not contribute, and the claim will be 100% taxable.

Employer Name and Title
Enter in the name and title of person completing this section of the form.

Employer Contact Email
Enter in the email address of the person completing this section of the form.

Employer Contact Phone #
Enter the best phone number for the person completing this section of the form.

Employer Signature / Date Signed
Signature of the person who completed this section of the form, as well as the date it was completed.

Direct Deposit Enrollment and Authorization Form for NY DBL and PFL

Direct Deposit Enrollment and Authorization Form for New York Disability Benefits Law ("DBL") and Paid Family Leave ("PFL") Claims Payments

INSTRUCTIONS

This form must be fully completed, signed, and dated to be valid. Incomplete, illegible or ineligible submissions are unable to be processed and will not be accepted.

Eligibility for Direct Deposit: ShelterPoint Life Insurance Company ("Company") offers Direct Deposit Payments for Disability Benefits (DBL) and Paid Family Leave (PFL) claims where benefit payments are being issued directly to the claimant/employee. Direct deposit is not available if the Company is reimbursing your Employer due to their continued payment of wages. In the event that a direct deposit payment is rejected due to inaccurate banking information, the rejected payment and any future benefit payments due under the claim will be issued via paper check (and delivered via the USPS) until the bank information has been corrected and an updated Enrollment and Authorization Form submitted.

REQUIRED CLAIMANT INFORMATION (please print all information LEGIBLY)

1. Claimant Name (First name, Last name)	2. Social Security Number or I-TIN (9 digits)

3. **ShelterPoint Life Claim Number(s)**

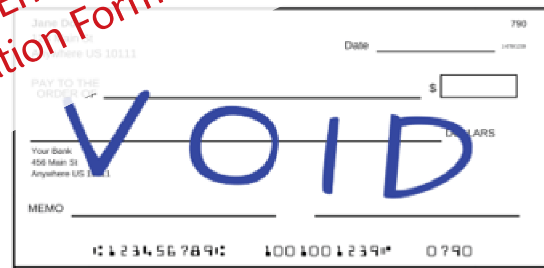
4. **Account Type:**
☐ Checking Account ☐ Savings Account

ATTACH PROOF OF BANKING INFORMATION

Examples of valid proof of banking include:

- A copy of a voided check with your name, address, bank name, routing number and account number listed; or
- A written statement from your bank confirming account holder name, address, bank name, routing number and account number

Failure to include proof of banking information may result in direct deposit not being established under an approved claim.



SUBMITTING YOUR DIRECT DEPOSIT REQUEST

You must supply all information requested on this form. Fully completed, signed and dated forms may be sent to ShelterPoint by any one of the below listed methods:

- Email: claimforms@shelterpoint.com
- Fax: (516) 504-6414
- Mail: ShelterPoint Life, Attn: Claims, 1225 Franklin Avenue, Suite 475, Garden City, NY 15530

If you have any questions regarding this form, please contact our Customer Service Department at 1-800-365-4999 during normal business hours. Please allow up to ten (10) business days for your direct deposit enrollment to be effective.

AUTHORIZATION AND SIGNATURE

I authorize ShelterPoint Life Insurance Company ("Company") to deposit any benefits I am eligible to receive directly into the bank account information that I have provided as an attachment to this form, or to such other account as the bank or any successor bank designates as my account. I also authorize the Company to debit my account for any deposits made in error, or the Company reserves the right to request the return of such funds through other mechanisms. I also understand that the direct deposit service will stay in effect until I notify the Company in writing of cancellation or until I am no longer eligible for or due payments, whichever comes first. I acknowledge that if I am also covered under another ShelterPoint state-mandated benefit policy, this request will also apply to any other current open claim(s) that are eligible for direct deposit, if approved by the Company. I understand that I have the opportunity to view my EOBs and payment history via claims portal registration on shelterpoint.com.

☐ Check this box if you **do not** want to receive paper EOBs in the mail if your direct deposit request is approved.

Claimant Signature	Date (mm/dd/yyyy)

38927711.2
SPL – NY DBL/PFL Benefits – Direct Deposit Request Form (6/2024)

Direct Deposit Enrollment and Authorization Form for NY DBL and PFL

PLEASE PRINT ALL INFORMATION LEGIBLY. This form must be fully completed, signed, and dated to be valid. Incomplete or ineligible submissions are unable to be processed and will not be accepted.

Eligibility for Direct Deposit: ShelterPoint offers Direct Deposit Payments for DBL and PFL claims where benefit payments are being issued directly to the claimant/employee.

PLEASE NOTE:

In the event that a direct deposit payment is rejected due to inaccurate banking information, the rejected payment and any future benefit payments due under the claim will be issued via check until the bank information is corrected, and an updated Enrollment and Authorization Form is submitted.

Question 1 - Claimant Name (First name, Last name)

Enter in the first and last name of the claimant.

Question 2 - Social Security Number or I-TIN

Enter in the SSN or nine-digit I-TIN of the claimant.

Question 3 - Claim Number(s)

Enter in any applicable DBL/PFL claims with us.

Question 4 - Account type

Indicate whether a checking account or savings account.

Authorization and Signature

Check the box if you do not wish to receive a paper copy of your EOB. Leave blank if you wish to receive a paper copy in the mail. Sign and date the form.

REMINDER: A completed enrollment form is required to participate in direct deposit. **Proof of banking/Account information is needed to establish Direct Deposit** (e.g. copy of voided check or letter from bank confirming accountholder name, address, routing number and account number).

MKTG# 24-44 | G5 06/24

24/7 Claim Management
for Employees

Create your free online account today for around-the-clock access to:

- Find out if you are eligible for benefit payments
- View your **current claim status** and see if you need to take any action to assure continued processing of your claim
- Upload additional forms and documents
- **See when your next check will be sent (DBL only)**
- Check the **history of the benefit payments** we've issued
- See which forms we sent and which forms we've received
- See **important notifications** regarding your claim
- Sign up for **alerts via email when you need to take action**
- Sign up to receive **claim forms electronically**
- Easily toggle between your DBL & PFL claims

Sign up and start managing your claim today!
www.shelterpoint.com/ClaimPortal

M#22-56b | G3- 05/24

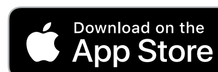
You can sign up once you receive your claim number.

Registration is fast and easy - you just need your:

1. Claim number
2. Social Security Number
3. Valid email address

ShelterPoint Claim Portal now available as a mobile app!

Search "ShelterPoint Claims" to download the app.



App Advantages:

- Snap a picture of your form and upload it. It gets to our claim examiners immediately
- Get push notifications on your home screen

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sales@shelterpoint.com | 800.365.4999 (516.829.8100)