

TO THE CLAIMANT: THE OFFICE IDENTIFIED AT THE RIGHT ISSUED THIS NOTICE.

NOTICE OF TOTAL OR PARTIAL REJECTION OF CLAIM FOR DISABILITY BENEFITS
 AVISO DE TOTAL O PARCIAL RECHAZO DE RECLAMACION DE BENEFICIOS POR INCAPACIDAD

THIS FORM MUST BE USED BY SELF-INSURED EMPLOYERS, UNIONS OR ASSOCIATIONS AND INSURANCE CARRIERS TO REJECT ALL OR PART OF A CLAIM FOR DISABILITY BENEFITS. This notice is to be mailed to the claimant in triplicate within 45 days, to give the claimant opportunity of filing the notice with the Chair, Workers' Compensation Board for the purpose of review. IMPORTANT: check each item on which claim is being rejected. If reason No. 5,7,9,or 10 is checked, enter explanation in space provided in No.11.

Claimant	Date of this Notice		Social Security No.
	First Day of Disability	Carrier Claim/File No.	Date Claim Received (by employer or carrier, whichever is earlier)
	Claim Filed (Check one) <input type="checkbox"/> DB-450 <input type="checkbox"/> C-7 (Sec.206.2) <input type="checkbox"/> DB-300 WCB Case No. _____		
Employer	Address		
Policy Holder or Union (If Different from Employer)	Address		
Benefits paid on this claim prior to the date of this notice <input type="checkbox"/> None <input type="checkbox"/> From _____ To _____ Amount Per Week \$ _____			

You are hereby notified that your claim for disability benefits is rejected for the reason(s) checked below:

1. Payment of benefits is rejected after _____ the date you could return to work according to medical vidence on file. If you were still disabled after that date, submit additional medical evidence immediately.
2. Your claim was filed more than 26 weeks after your disability began.
3. Notice and proof of disability was not furnished within 30 days (See Dates Above.) after disability began. (See item 4 on reverse.)
 (A) No benefits payable.
 (B) Payments are being made beginning 2 weeks prior to the date your claim was received.
 Benefits are payable from _____
4. We are not your last employer's Disability Benefits Insurance carrier.
 (A) Your claim has been forwarded to: _____
 (B) Your claim is returned herewith. We suggest you give it to your employer for submission to the proper carrier or forward it to the Workers' Compensation Board, Disability Benefits Bureau, 100 Broadway-Menands, Albany, NY 12241-0005.
5. Your record of employment is not sufficient to establish your eligibility for disability benefits. PLEASE SEE ITEM NO. 11.
6. Your disability began more than 4 weeks after your employment terminated. Your claim, together with copies of this notice and our related records, is being forwarded to the Workers' Compensation Board, Special Fund for Disability Benefits, for consideration.
7. You have received either 26 weeks of benefits, the maximum payable during a period of 52 consecutive weeks or for any one disability; or you have received the maximum payable under a Disability Benefits plan filed with the Workers' Compensation Board. PLEASE SEE ITEM NO. 11.
8. Your disability arose out of and in the course of your employment. We suggest you notify your employer and obtain a claim for Workers' Compensation (Form C-3) from the nearest Workers' Compensation Board Office.
9. You failed to furnish, as requested, information necessary to process your claim. PLEASE SEE ITEM NO.11.
10. Other - PLEASE SEE ITEM NO.11

11. Explanation

Signature


Title

Telephone No. and Extension

TO CLAIMANT: READ IMPORTANT INSTRUCTIONS FOR REQUESTING REVIEW ON REVERSE SIDE.

AL RECLAMANTE: LEA LAS INSTRUCCIONES IMPORTANTES PARA SOLICITAR REVISION AL REVERSO DE ESTA FORMA.

CLAIMANT'S REQUEST FOR REVIEW

MAIL TO : 

WORKERS' COMPENSATION BOARD
DISABILITY BENEFITS BUREAU
100 BROADWAY-MENANDS
ALBANY, NY. 12241-0005

I acknowledge receipt of Notice of Rejection of my claim for Disability Benefits. I hereby request a review of the rejection of such claim for the following reasons: (Give complete details).

Acuso recibo de la notificacion de denagacion de mi reclamacion de beneficios por incapacidad. Solicito una revision de dicha decision, por las siguientes razones: (De detalles completos).

Social Security No. _____ Telephone Number _____

Date _____ Claimant's Signature _____

INSTRUCTIONS TO CLAIMANT

INSTRUCCIONES AL RECLAMANTE

1. If you do not agree with this rejection of your claim, complete the above statement. You should file your Request for Review within 26 weeks.
2. Give SPECIFIC reasons for requesting a review for each item of rejection checked on the face of this form.
3. Attach any medical evidence, employment records, and/or any other evidence, which you feel will support your request for review.
4. You may request that late filing be excused by the Chair, Workers' Compensation Board, if it was not reasonably possible to file within 30 days after disability began and filing was done as soon as possible.
5. Complete all copies of this form received from your employer or insurance company.
6. Mail two copies PROMPTLY to the above address.

1. Si no está conforme con este rechazo de su reclamación, complete este documento. Usted debe mandar su Aviso de Rechazo antes de 26 semanas.
2. De usted las razones ESPECIFICAS que le hacen solicitar revisión, con respecto a cada punto de rechazo chequeado en el frente de este formulario.
3. Adjunte a esta formulario Certificados Médicos, Antecedentes de Empleo y Desempleo y/o cualquier otro documento que usted entienda hayan de apoyar su solicitud de revisión.
4. Usted puede solicitar que la presentación tardía de su reclamación le sea disculpada por la Presidencia (Chair) de la Junta de Compensacion Obrera, si a usted no le fue razonablemente posible presentar su reclamación dentro de los 30 días desde la fecha del comienzo de su incapacidad y si hizo dicha presentación lo mas pronto que le fue posible hacerlo.
5. Complete ambas copias de esta forma.
6. Envíe por correo, PRONTAMENTE, dos copia a la dirección indicada arriba.