

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

PART A - CLAIMANT'S STATEMENT

Claimant: Read the following instructions carefully.

1. Use this form if you become sick or disabled while employed with Putnam County.
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 and until 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 Putnam County Risk Management Office.
6. Make a copy of this completed form for your records before you submit it.

PLEASE PRINT or TYPE -- ANSWER ALL QUESTIONS

1. My name is: _____

FIRST MIDDLE LAST

SOCIAL SECURITY NUMBER:

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2. Address: _____

NUMBER STREET CITY OR TOWN STATE ZIP CODE APT NO.

3. Tel. No.: _____ 4. Date of Birth: _____ 5. Married (Check one): Yes No

6. My disability is (if injury, also state HOW, WHEN and WHERE it occurred) _____

7. I became disabled on: _____ a. I worked that day: Yes No

MONTH DAY YEAR

b. I have since worked for wages or profit: Yes No If "Yes" give dates: _____

8. Name of your County government department . If you had more than one employer during the last eight (8) weeks, name all employers:

Employer Name	Employer Address	Telephone No.	DATES of EMPLOYMENT						AVERAGE WEEKLY WAGES <small>(Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)</small>
			FROM			THROUGH			
			MO.	DAY	YEAR	MO.	DAY	YEAR	

9. My job is or was: _____

OCCUPATION NAME OF UNION, IF MEMBER

10. For the period covered by this claim:

a. Are you RECEIVING wages, salary or separation pay: Yes No

b. Are you RECEIVING or CLAIMING:

1) Worker's Compensation for work-connected disability: Yes No 2) Unemployment Insurance Benefits: Yes No

3) Damages for personal injury: Yes No 4) Benefits under the Federal Social Security Act for long-term disability: Yes No

If "YES" is checked in any of the items in 10.a. or 10.b., complete the following:

I have received claimed from _____ for the period: _____ to _____

DATE DATE

11. I have received disability benefits for another period or periods of disability within the 52 weeks immediately before my present disability began: Yes No If "YES," fill in the following: I have been paid by _____ from _____ to _____

DATE DATE

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

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

Claim signed on _____

DATE CLAIMANT'S SIGNATURE

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

DISCLOSURE OF INFORMATION: PUTNAM COUNTY WILL NOT DISCLOSE ANY INFORMATION ABOUT YOUR CLAIM TO ANY UNAUTHORIZED PARTY WITHOUT YOUR CONSENT. IF YOU CHOOSE TO HAVE SUCH INFORMATION DISCLOSED TO AN UNAUTHORIZED PARTY, YOU MUST NOTIFY THE COUNTY.

If you have any QUESTIONS about claiming disability benefits, contact: PUTNAM COUNTY RISK MANAGEMENT OFFICE - 845-808-1150 48 Gleneida Avenue, Carmel, NY 10512

HEALTH CARE PROVIDER MUST COMPLETE PART B ON REVERSE SIDE

