Prepare. Protect. Prevail.®

Important Information to Assist with Completion of DB 450 Claim Form - Part C

Valued Customer:
There are two sections of the DB 450 Claim Form (Employer Section Part C) where clarification may be helpful. We hope this document will aid in completion of the claim form.

Requesting Reimbursement:

In the Employer Section (Part C) of the DB 450 Claim form, we ask if wages were paid during the disability period, and whether or not the employer wishes to be reimbursed by The Hartford.

Article 9 (NY DBL Law) § 237 of the New York Workers' Compensation Law states an employer, may be reimbursed by the New York DBL carrier during a claim for any time the employer has advanced monies to the claimant if the claim for reimbursement is filed with the carrier prior to payment of benefits by the carrier. Here are some items for your consideration when determining whether or not to be reimbursed by The Hartford:

- Advancement of monies by the employer must be employer-sponsored monies.
- Vacation and PTO time are not considered employer-sponsored, but instead are considered employee-earned time, and thus are not a reduction to DBL benefits nor a basis for reimbursement.
  Note: Required sick time via state or city ordinances (e.g. NYC) may not be considered employer-sponsored and therefore benefits may be payable to the employee.
- Salary continuation and sick time are considered employer-sponsored and are reimbursable by The Hartford.
  Note: Required sick time via state or city ordinances (e.g. NYC) may not be considered employer-sponsored and therefore may not be reimbursable.
- Reimbursement of benefit money to the employer allows the employer to continue salary, and withhold the appropriate FICA taxes.
- Reimbursed funds from The Hartford are payable to the employer and taxes are not withheld.
- When requesting reimbursement, be sure to include the entire period of time that reimbursement is requested should the claim extend to full duration of New York DBL.

For more information, please visit: http://www.wcb.ny.gov/content/main/Employers/EmployerHandbook.pdf

Taxability of Benefits:

Please see the below excerpt from IRS Publication 15A to assist you in calculating the taxable percent of benefits. Taxability is expected to be less than 100 percent when the employee is contributing to the cost of the coverage.

Excerpt from IRS Publication 15A, Page 17 and 18: ***Group policy.*** If both the employer and the employee contributed to the sick pay plan under a group insurance policy, figure the taxable sick pay by multiplying total sick pay by the percentage of the policy's cost that was contributed by the employer for the 3 policy years before the calendar year in which the sick pay is paid. If the policy has been in effect fewer than 3 years, use the cost for the policy years in effect or, if in effect less than 1 year, a reasonable estimate of the cost for the first policy year.

Example. Alan is employed by Edgewood Corporation. Because of an illness, he was absent from work for 3 months during 2015. Key Insurance Company paid Alan $2,000 sick pay for each month of his absence under a policy paid for by contributions from both Edgewood and its employees. All of the employees' contributions were paid with after-tax dollars. For the 3 policy years before 2015, Edgewood paid 70% of the policy's cost and its employees paid 30%.

Because 70% of the sick pay paid under the policy is due to Edgewood's contributions, $1,400 ($2,000 × 70%) of each payment made to Alan is taxable sick pay. The remaining $600 of each payment that is due to employee contributions is not taxable sick pay and is not subject to employment taxes. Also, see *Example of Figuring and Reporting Sick Pay*, later in this section.

For more information please visit: https://www.irs.gov/pub/irs-pdf/p15a.pdf

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

CLAIMANT: READ THE FOLLOWING INSTRUCTIONS CAREFULLY

1. USE THIS FORM IF YOU BECOME SICK OR DISABLED **WHILE EMPLOYED** OR IF YOU BECOME SICK OR DISABLED **WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT.** USE 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 - THE **"CLAIMANT'S STATEMENT"**. BE ACCURATE. CHECK ALL DATES.
3. BE SURE TO DATE AND SIGN YOUR CLAIM (SEE ITEM 15). IF YOU CANNOT SIGN THIS FORM, YOUR REPRESENTATIVE MAY SIGN IT ON YOUR BEHALF. IN THAT EVENT, THE NAME, ADDRESS AND REPRESENTATIVE'S RELATIONSHIP TO YOU SHOULD BE NOTED UNDER THE SIGNATURE.
4. **DO NOT MAIL THIS CLAIM UNLESS YOUR HEALTH CARE PROVIDER COMPLETES AND SIGNS PART B - THE "HEALTH CARE PROVIDER'S STATEMENT.**
5. YOUR COMPLETED CLAIM SHOULD BE MAILED **WITHIN THIRTY (30) DAYS AFTER YOU BECOME SICK OR DISABLED TO YOUR LAST EMPLOYER OR YOUR LAST EMPLOYER'S INSURANCE COMPANY The Hartford P. O. Box 14301 Lexington, KY 40512-4301 Fax 1-866-411-5613.**
6. MAKE A COPY OF THIS COMPLETED FORM FOR YOUR RECORDS BEFORE YOU SUBMIT IT.

Read instructions on page 3 carefully to avoid a delay in processing. You must answer all questions in Part A and questions 1 through 3 in Part B. Health care providers must complete Part B on page 2.

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 #: _____ Email Address: _____
4. Social Security #: ____ - ____ - _____ 5. Date of Birth: ___ / ___ / _____ 6. Gender ☐ Male ☐ Female ☐ 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 PRIOR TO DISABILITY			PERIOD OF EMPLOYMENT		**Average Weekly Wage** (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
Firm or Trade Name	Address	Phone Number	First Day	Last Day Worked	
			Mo. Day Yr.	Mo. Day Yr.	
OTHER EMPLOYER (during last eight (8) weeks)			**PERIOD OF EMPLOYMENT**		**Average Weekly Wage** (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
Firm or Trade Name	Address	Phone Number	First Day	Last Day Worked	
			Mo. Day Yr.	Mo. Day Yr.	
			Mo. Day Yr.	Mo. Day Yr.	

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: _____
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: ____ / ____ / _____

PART A - CLAIMANT'S INFORMATION (Continued)

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 on page 4 of this form and 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 he or she is 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. For item 7-d, you must give estimated date. 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: ☐ Male ☐ Female ☐ 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 Form C-4 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 #**

IMPORTANT NOTICE TO CLAIMANT - READ THESE INSTRUCTIONS CAREFULLY

PLEASE NOTE: Do not date and file this form prior to your first date of disability. In order for your claim to be processed, Parts A and B must be completed.

1. If you are using this form because you became disabled **while employed** or you became disabled **within four (4) weeks after termination of employment**, your completed claim should be mailed **within thirty (30) days of your first date of disability to your employer or your last employer's insurance carrier**. You may find your employer's disability insurance carrier on the Workers' Compensation Board's website, www.wcb.ny.gov, using Employer Coverage Search.

2. If you are using this form because you became **disabled after having been unemployed for more than four (4) weeks**, your completed claim MUST be mailed to: **Workers' Compensation Board, Disability Benefits Bureau, PO Box 9029, Endicott, NY 13761-9029**. If you answered "Yes" to question 13.B.3, please complete and attach Form DB-450.1.

If you do not receive a response within 45 days or if you have questions about your disability benefits claim, please call your employer's insurance carrier. For general information about disability benefits, please visit www.wcb.ny.gov or call the Board's Disability Benefits Bureau at (877) 632-4996.

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 part, 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 or visit our nearest Customer Service Center to obtain a copy of the form. In lieu of Form OC-110A, you may also submit an original signed, notarized authorization letter.

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.

The Hartford
P. O. Box 14301
Lexington, KY 40512-4301
Fax 1-866-411-5613

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

PART C - EMPLOYER'S STATEMENT

Employee's full name: (As shown on Social Security Card) | Social Security Number:

Employee's Address: (Street, City, State & Zip Code) | Date of Birth:

Date of employment: _____ ☐ Full Time ☐ Part Time

Check days normally worked: Sun. Mon. Tues. Wed. Thurs. Fri. Sat.

If Part Time, give particulars:

Is employee a Union member? ☐ Yes ☐ No

If "Yes," is employee entitled to Union Benefits ☐ Yes ☐ No

Occupation:

Date employee last worked:

Date employee returned to work:

Were wages continued during disability? ☐ Yes ☐ No

Were wages employer-sponsored sick pay? ☐ Yes ☐ No From: _____ To: _____

Were wages Vacation, PTO, or Mandated Sick Time (e.g. NYC)? ☐ Yes ☐ No From _____ To _____

Is reimbursement requested? ☐ Yes ☐ No

Is disability due to job? ☐ Yes ☐ No

If "Yes," has a compensation claim been filed? ☐ Yes ☐ No

Indicate Weekly Value of Board, Lodging and Tips:

Is this employee currently covered by Social Security? ☐ Yes ☐ No

If "No," state grounds for exemption:

EARNINGS 8 WEEKS PRIOR TO AND INCLUDING THE DATE LAST WORKED PRIOR TO THE ONSET OF DISABILITY.

Month	Day	Year	No. Days Worked	Amount
			Total	

Is employee enrolled in a Hartford Long Term Disability Plan?
☐ **Yes** ☐ **No** **If "Yes," effective date.** _____ **Hartford NY Disability Policy Number:** _____

Based on the employer/employee premium contributions made over the last 3 years, what percentage of the Weekly Disability benefit it is considered taxable? _____ **% LTD** _____ **% (See section 6 of IRS Publication 15-A for information on determining the taxable percentage.)** *(If blank, we will code the benefit as 100% taxable until you submit written notice of the correct taxable %.)*

Employer's Name: Mohawk ESV | Employer's Identification Number:

Address: (Street, City, State & Zip Code) 160 S. Industiral Boulevard, Calhoun, GA 30701 | Telephone Number: (866) 481-4922

Signed by: | Date: | Title:

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

Signature - Please read the statement that applies to your state of residence and sign the bottom of the second page.

With the exception of any source(s) of income reported above in this form, I certify by my signature that I have not received and am not eligible to receive any source of income, except for my disability benefits from this plan. Further, I understand that should I receive income of any kind or perform work of any kind during any period The Hartford has approved my disability claim, I must report all details to The Hartford, immediately. If I receive disability income benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the Plan. The Hartford has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed.

For residents of all states EXCEPT Arizona, Alabama, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For Residents of Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

For Residents of California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance 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.

For residents of Maine, Tennessee, and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

For Residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit and who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

For residents of Ohio: Any person who, with intent to defraud or knowing he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature - Please read the statement that applies to your state of residence and sign the bottom of the page.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

For residents of Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

The statements contained in this form are true and complete to the best of my knowledge and belief.

_____ _____

Signature Date

Electronic Funds Transfer (EFT) is our standard method of payment. When making our claim decision we may contact you to obtain your banking information.

NEW YORK STATE | Workers' Compensation Board

STATEMENT OF RIGHTS
NEW YORK STATE DISABILITY BENEFITS

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. The total amount of combined paid family and disability leave an employee may take in a 52 consecutive week period may not exceed 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 and Paid Family Leave Benefits Law. Your employer's disability benefits insurance carrier is:

The Hartford
P. O. Box 14301
Lexington, KY 40512-4301
Fax 1-866-411-5613

Prescribed by the Chair,
Workers' Compensation Board