

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 – DOCTOR'S STATEMENT (Please Print or Type)

The doctor's statement must be filled in completely. For Item 7-d, give approximate date. Make some estimate. Delay in the payment of Disability Benefits may be prevented. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date under "Remarks."

1. Claimant's Name 2. Age 3. Male
 Female

First Middle Last

4. Diagnosis/Analysis:
 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:

	Mo.	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 considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)

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-4/48 been filed with the Workers' Compensation Board? YES NO

Remarks (Attach additional sheet, if necessary):

9. I affirm that I am a Licensed in the State of License No.
(Physician, Podiatrist, Chiropractor, Dentist)

Doctor's Signature Date
 Doctor's Name (Please Print) Tel. No.
 Office Address
 Number Street City or Town State Zip Code