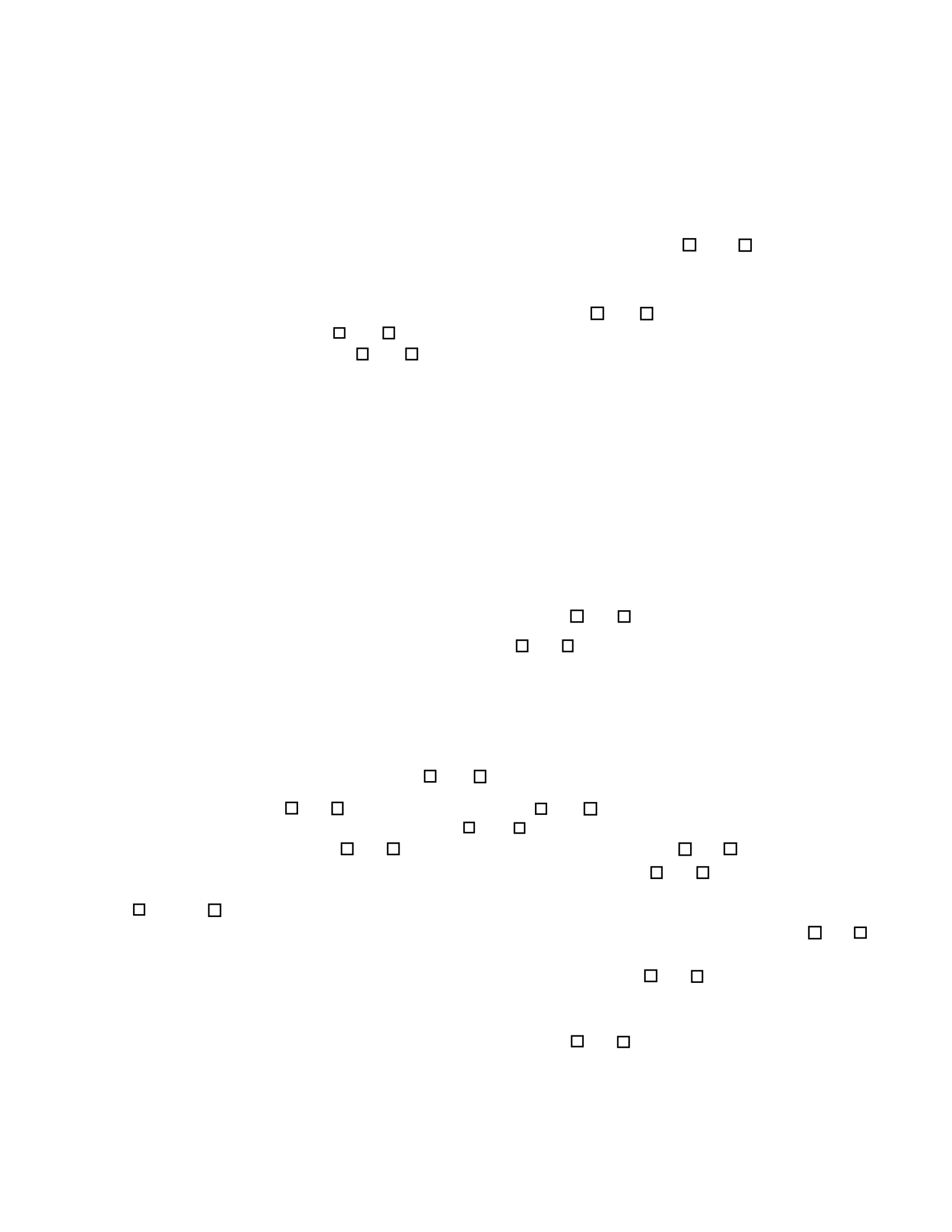

PART B - HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type)

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 9. **INCOMPLETE ANSWERS MAY DELAY PAYMENT OF BENEFITS**.

1. Last Name: _____ First Name: _____ MI: __

2. Gender: ☐ Male ☐ Female 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 #**

Part C - EMPLOYER'S STATEMENT

1. Employee's Name: _____ **2.** Soc. Sec. #: ☐☐☐ ☐☐ ☐☐☐☐

3. Employee's Address: _____
Number Street Apartment Number City / Town State Zip Code

4. Employee's Occupation: _____ **5.** Date of Hire: _____ **6.** Status: ☐ Full Time ☐ Part Time

7. Is the Claimant an: ☐ Employee ☐ Owner ☐ High School Student **7a.** Date of Birth _____

8. Indicate the employee's normal work schedule: ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun

9. If the employee is no longer in your employ, explain why: ☐ Quit ☐ Fired ☐ Laid Off ☐ Other (explain) _____

10. Date Employee last worked: _____ **10a.** Do you expect to rehire him/her? ☐ YES ☐ NO

11. Date Employee returned to work: _____

12. Are you paying wages or sick time: ..... ☐ YES ☐ NO

a. If **YES,** time period paid: _____

b. Are you requesting reimbursement for this time period? ..... ☐ YES ☐ NO

13. Is Employee receiving or claiming Unemployment Ins? ..... ☐ YES ☐ NO

14. Is Employee receiving or claiming Workers' Comp. Ins? ..... ☐ YES ☐ NO

15. Did this Disability occur as a result of employment? ..... ☐ YES ☐ NO

16. Is Employee in a Union proving **MONETARY DISABILITY BENEFITS?** ..... ☐ YES ☐ NO

17. Are you aware of other employment claimant may have? ..... ☐ YES ☐ NO

18. Has the employee received DBL or PFL benefits within the past 52 weeks? ☐ YES ☐ NO

19. TAXABLE PERCENTAGE _____ %

POLICY NUMBER: _____

Weekly Wages 8 Weeks prior to Last Day Worked Before Disability
(include value of Board, Lodging, and Tips if any)

	Week Ending Month Day Year	No. of Days Worked	GROSS WEEKLY WAGES
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
		TOTAL	

EMPLOYER INFORMATION:

Employer Name: _____ Employer Address: _____

Phone: _____ Fax: _____ E-mail: _____

Print Name: _____ Sign: _____ Title: _____ Date: _____

After Parts A, B, & C are COMPLETED, Do one of the following: SSLICNY Phone: 800-477-0087 or 585-398-2340

Mail to: SSLICNY, P.O. Box 25339 Farmington, NY 14425 or Fax to: 585-398-2854 or E-mail to: claims@sslicny.com