



DISABILITY BENEFITS LAW
EMPLOYER IDENTIFICATION INFORMATION

For use by employee when filing a claim for Disability Benefits for off-the-job injury or illness.
DISABILITY BENEFITS HAVE BEEN PROVIDED BY:

Employer Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Employer Phone #: _____ Employer FEIN: _____

Disability Benefits Insurer: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Insurer Phone #: _____ DB Policy #: _____

If the employer noted above is your last employer and you became disabled while still employed or if you become disabled within four (4) weeks after termination of employment and need to file a claim for Disability Benefits while you are unemployed, you should file a claim Notice and Proof of Claim for Disability Benefits (Form DB-450) with this employer or it's Disability Benefits insurance carrier.

If you become disabled after having been unemployed for more than four (4) weeks file a claim Notice and Proof of Claim for Disability Benefits (Form DB-450) with the NYS Workers' Compensation Board at:

Workers' Compensation Board
Disability Benefits Bureau
PO BOX 9029
Endicott, NY 13761-9029

Additional information on Disability Benefits can be found at www.wcb.ny.gov or by calling the Disability Benefits Bureau at (877) 632-4996.