NOTICE OF DISABILITY BENEFITS PAYMENT

MAIL TO: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU
328 STATE STREET, SCHENECTADY, NY 12305

- PLEASE PRINT OR TYPE -

1. SOCIAL SECURITY NO.	2. DATE OF FIRST PAYMENT	3. CARRIER'S FILE NO.	4. WEEKLY BENEFIT AMOUNT

5. CLAIMANT'S NAME AND ADDRESS

6. BENEFIT PERIOD:	Mo. Day Year
a.FROM	
b.THROUGH(Estimated)	
c.THROUGH (Final)	

PRINT CARRIER NAME AND ADDRESS HERE

7. OTHER BENEFITS OR WAGES FOR ALL OR PART OF PERIOD REPORTED IN ITEM 6 ABOVE (See Instructions)

WKLY AMNT	FROM	THROUGH

Other:

SEE REVERSE SIDE FOR INSTRUCTIONS

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

DB-455 (3-99)

1. CARRIERS SHOULD COMPLETE AND FILE FORM DB-455 PROMPTLY ON MAKING INITIAL PAYMENT OF DISABILITY BENEFITS TO AN UNEMPLOYED CLAIMANT.

2. MAIL TO: WORKERS COMPENSATION BOARD
DISABILITY BENEFITS BUREAU
328 STATE STREET
ALBANY, NY 12241-0005

Item 2: Give date first Disability Benefit payment was made to claimant on the current claim.

Item 6a: Give beginning date of period for which Benefits are payable to claimant.

Item 6b: Give estimated ending date of claimant's period of disability if final ending date is not known at time of initial payment. If estimate is later changed, file amended Form DB-455.

Item 6c: Give final ending date of claimant's period of disability if known at time of initial payment; otherwise omit this item but file amended completed Form DB-455 as soon as final ending date is determined.

Item 7: Give amount of other benefits or wages received or claimed by the claimant for all or part of the period reported in Item 6, if known. Other benefits or wages may include salary, separation pay, benefits or damages for personal injuries, benefits under a workers' compensation law, unemployment insurance law, old age and survivor's insurance, the maritime doctrine of maintenance, wages and cure, or similar benefits. If surgical, medical or hospital benefits, give total amount and if paid, date of payment.