standardsecurity
LIFE INSURANCE COMPANY
P.O. Box 25339 Farmington, NY 14425
phone 800-477-0087
claims@sslicny.com

New York State
REQUEST FOR EMPLOYMENT AND WAGE VERIFICATION

PART C - EMPLOYER INFORMATION (to be completed by the employer)

1. Business's full legal name and mailing address **NY DBL Policy Number:** _____

Business Name _____

Mailing Address _____

City, State _____

Zip Code _____

Country (if not U.S.A.) _____

2. Employer's FEIN: _____

3. Contact Information:

Employer's contact name for questions relating to disability: _____

Employer's contact telephone number: _____ **Fax number:** _____

Employer's contact email address: _____

4. Is the employee a member of a union that provides the statutory disability benefits? ☐ Yes ☐ No

*If yes, provide Union name, address, and contact information _____

_____

5. Employee Information:

Employee Name: **Employee Occupation:**

Employee's role: ☐ Employee ☐ Proprietor ☐ Partner ☐ Spouse of Employer ☐ Owner ☐ Co-Owner

Employee's date of hire (MM/DD/YYYY): _____ **Is employee Full Time or Part Time?** ☐FT ☐PT

Date employee last worked: _____

Work Week: **Mon** ☐ **Tue** ☐ **Wed** ☐ **Thu** ☐ **Fri** ☐ **Sat** ☐ **Sun** ☐

Date employee returned to work (if applicable):

6. Were wages continued during disability? ☐ Yes ☐ No

If yes, what type? (PTO, sick time, other): _____

If yes, is reimbursement requested by employer? ☐ Yes ☐ No

***Reimbursement is only available if employer continued salary during disability or employee used sick time**

If yes, for what dates? From: _____ **Through:** _____

7. Is the employee's disability work-related? ☐ Yes ☐ No

8. Enter the last 8 weeks of gross wages for the employee immediately prior to the disability starting with the week the disability began, and calculate the average gross weekly wage (include bonuses, tips, commissions, reasonable value of board, rent, etc. and see instructions for more information)

Week No.	Week ending date (MM/DD/YYYY)	No. of days worked	Gross amount paid
1			$0.00
2			$0.00
3			$0.00
4			$0.00
5			$0.00
6			$0.00
7			$0.00
8			$0.00
		Calculated average gross weekly wage:	$0.00

9. In the preceding 52 weeks has the employee taken leave for:

☐ NYS Disability ☐ PFL ☐ Both Disability and PFL ☐ None

Disability: Please provide specific dates for disability _____

PFL: Please provide specific dates for PFL _____

10. Is employee still in your employment? ☐ Yes ☐ No

If no, date employment was terminated: _____

11. If employee received unemployment benefits, date the benefit was last received: _____

PART C - EMPLOYER INFORMATION (to be completed by the employer)

I have read and acknowledge the fraud information below and affirm that to the best of my knowledge and belief, the information I have provided is true and accurate.

Employer Name and Title: _____

Employer Signature: _____

Employer Contact Phone Number: _____

Date: _____

After Parts A, B, & C are COMPLETED, do one of the following:

Mail to: SSLICNY, P.O. Box 25339 Farmington, NY 14425, or

Fax to: 585-398-2854, or

E-mail to: claims@sslicny.com

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 party, 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. In lieu of Form OC-110A, you may also submit an original signed, notarized authorization letter.

FRAUD ACKNOWLEDGEMENT - 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.