Checklist for Requesting New York Disability Benefits (NY DBL)

Before you apply for NY DBL

☐ **Understand your rights - Review form DB271S - Statement of Rights (enclosed)**

☐ **Notify your employer as soon as possible.** Your employer should also provide you with a statement of rights (DB271S) within 5 days. Your health condition may also be covered under other program(s) administered by or offered by your employer (e.g. FMLA, employer provided STD, paid sick leave, etc.). Understand all of your leave options before filing.

Prepare Claim Documentation

Form DB450: The DB450 claim form is a 3-part form developed by the Workers' Compensation Board. **Part A** is completed by you, **Part B** by your treating health care provider, and **Part C** by your current or former employer. Ensure all 3 sections are completed **in full**. All sections must be signed and dated by the respective party. Please print clearly– incomplete or illegible claim packages may result in processing delays. Copies of all documents should be retained for your records.

☐ **Complete Part A - Claimant's Statement** Sign and date the form after you have stopped working. Refer to our DB450 guide if you need additional help completing this section of the form.

☐ **Your health care provider (HCP) completes Part B – Health Care Provider's Statement** Part B should be completed on or after your first day of disability and returned to you within seven (7) days.
Note: The following HCPs are authorized to certify disability benefits: Physician, Dentist, Chiropractor, Podiatrist, Psychologist, and Nurse-Midwife. The most common reason for a delay of benefit payment is due to failing to fully complete Part B. Failing to provide dates in question 7, or using terms such as "unknown or TBD" may delay our ability to make a claim determination. For pregnancy-related conditions, the HCP should indicate delivery date and type (if known), as well as any complications that may extend the disability period.

☐ **Your employer completes Part C - Employer's Statement** Your employer should return the completed employer's statement to you within 3 business days and retain a copy for their files. If you have more than one NY Employer, a completed employer's statement is required from each employer and should be included in your claim filing. If your employer(s) fails to return the completed form to you within 3 business days, include your most recent 8 weeks of pay stubs in your claim submission.

Form DB450 Supplement: Also included in the package to be completed is a **ShelterPoint DB450 Supplement**, which contains 2 parts; **Part 1** (to be completed by you regarding benefit payment preferences), and **Part 2** (to be completed by your employer, regarding taxability). Ensure both sections are completed **in full**.

Submit fully completed claim package within 30 days of your first day of leave.

Forms should not be completed/submitted in advance of the first day of leave. Completed claims for NY DBL benefits, and updates to existing claims, can be submitted to ShelterPoint by any of the below listed methods (choose one- do not submit by multiple methods). If sending in updated information on an existing claim, always include your claim number and first and last name in any correspondence sent.

Email: claimforms@shelterpoint.com
Fax: 516-504-6414
Mail: ShelterPoint Life, Attn: Claims Department, 1225 Franklin Avenue, Suite 475, Garden City NY 11530

What you can expect once your claim is submitted and claim number has been assigned:

Within a few business days of receiving your claim package, we will review it for completeness. If there is any missing information, we will reach out to you either by phone or in writing. It is your responsibility to provide the requested information so we can make a decision on your claim.

If your claim is approved, you can expect to receive benefit payments bi-weekly (every two weeks), as long as information remains up-to-date (and available benefits have not been exhausted). In some situations, benefits may be payable to your employer if wages were continued during the leave period through a salary continuation program or the use of accrued sick time. If we receive new information that requires review, payment may be delayed while your claim is in the review process. Payments may vary in duration/amount depending on specific factors i.e., the amount of leave available, when your last payment was issued and through which leave dates.

If you receive a denial of benefits from ShelterPoint, you have the right to request review of this decision by ShelterPoint or the Workers' Compensation Board. If you have additional information that may change our decision, please submit the information promptly for our review. Include your ShelterPoint claim number and first and last name in any correspondence sent.

New York State Disability Benefits
STATEMENT OF RIGHTS

NEW YORK STATE | Workers' Compensation Board

If you are unable to work due to a non-occupational illness or injury, you may be entitled to disability benefits.

1. You may be entitled to statutory disability benefits for a non-work-related injury or illness (including disability due to pregnancy) beginning with the eighth consecutive day of disability. Disability benefits are paid **directly to you** by your employer's insurer, **not** through your employer, unless your employer is an approved self-insurer. You can take up to 26 weeks of disability at 50% of your average weekly wage, capped at $170 per week. Generally, your average weekly wage is the average of your last eight weeks of pay prior to starting disability. Your employer or union may provide different benefits, at least as favorable as statutory, under an approved disability benefits plan or agreement.
2. If you also take New York State (NYS) Paid Family Leave (PFL), your combined total disability leave and PFL in any consecutive 52-week period may not exceed 26 weeks. You cannot take PFL and disability leave at the same time.
3. You can be treated by any physician, podiatrist, chiropractor, dentist, nurse midwife, or psychologist who can certify your disability. Your medical bills are not covered, unless your employer and/or union provides for the payment of medical bills under an approved disability benefits plan or agreement.
4. Your employer may **not** ask you to waive your right to disability benefits. Employers may collect a maximum contribution of 60 cents/week to offset the insurance premium (unless the additional contribution is part of an approved plan). **You cannot be discriminated or retaliated against for requesting or taking disability benefits.**
5. Your employer or employer's insurer is required to begin payment or issue a ***Notice of Denial (Form DB-DEN)*** or ***Notice of Rejection (Form DB-451)*** within 18 days of your first day of disability leave or receipt of your completed claim, whichever is later. If you receive ***Form DB-DEN***, you will also receive ***Form DB-451*** with additional information within 45 days of your first day of disability leave or the receipt of your completed claim, whichever is later. If after these 45 days, you have not received benefits or ***Form DB-451***, promptly contact the NYS Workers' Compensation Board (Board) at **(877) 632-4996**. NOTE: If you receive ***Form DB-451*** and disagree, you may request a review by writing to the Board at the bottom right address.

To file a claim:

1. Obtain a ***Notice and Proof of Claim for Disability Benefits (Form DB-450)***, either from the Board at **wcb.ny.gov**, or from your employer, or your employer's insurer.
2. Follow instructions to complete/submit the form, which includes sections your employer and health care provider must complete.
3. Submit the form to your employer's insurer within 30 days of your first day of disability. If your claim is not paid promptly, contact your employer or their insurer. If you file late, you may not be paid for any disability period more than two weeks before the date you filed. Late filings may be excused if you can show it wasn't reasonably possible to file earlier. No benefits are payable if you file more than 26 weeks after your disability begins, or after you return to work.

Do not assume that your employer has filed a claim on your behalf: filing a claim is your responsibility.

Note: If your disability is the result of an automobile accident, and you have filed a claim for no-fault benefits, **you must** also file a ***Form DB-450*** for disability benefits. If you do not file for disability benefits, the no-fault insurer may reduce your no-fault payments.

IMPORTANT: In such cases, if you are not entitled to disability benefits, immediately advise the no-fault insurer.

FOR HELP OBTAINING A CLAIM FORM OR FILLING IT OUT, OR OTHER QUESTIONS ABOUT BENEFITS FOR YOUR NON-WORK-RELATED INJURY OR ILLNESS, PLEASE CALL (877) 632-4996. A BOARD REPRESENTATIVE WILL HELP.

This information is a simplified presentation of your rights as required by Section 229 of the Disability and Paid Family Leave Benefits Law.
Your employer's disability benefits insurance carrier is:

ShelterPoint Life Insurance Company
Phone: 800-365-4999
1225 Franklin Avenue, Ste. 475
Garden City, NY 11530

PRESCRIBED BY THE CHAIR,
WORKERS' COMPENSATION BOARD
NYS Workers' Compensation Board
Disability Benefits Bureau
PO Box 9029, Endicott, NY 13761-9029

WCB.NY.GOV

DB-271S (12/23)

SHELTERPOINT

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

How to request Disability Benefits

Do not submit this form prior to your first date of disability. You must submit your completed claim form within 30 calendar days of your first day of disability to avoid losing benefits. Keep a copy of all forms and documentations for your records.

1. If you are using this form because you became disabled **while employed** or you became disabled **within four (4) weeks after termination of employment**, your completed claim should be submitted to your employer or your last employer's insurance carrier. You may find your employer's disability insurance carrier on the Workers' Compensation Board's website, www.wcb.ny.gov, using Employer Coverage Search.
2. If you are using this form because you became **disabled after having been unemployed for more than four (4) weeks after termination of employment**, your completed claim MUST be mailed to: **Workers' Compensation Board, Disability Benefits Bureau, PO Box 9029, Endicott, NY 13761-9029**. If you answered "Yes" to question 13.B.4., please complete and attach Form DB-450.1.

Note: This form has a section to be filled out by your healthcare provider, and a section to be completed by your employer. Before providing the form to your employer, fill out your section and make a copy to keep.

- The health care provider is required to return the form to you with Part B completed within seven days. If there is a delay, you must wait to submit the form to your insurance carrier. If Part B is not complete (or has incomplete answers) there may be delay in the payment of benefits.
- Your employer is required to return the form to you with Part C completed within three business days. If there is a delay, you do not have to wait to proceed – you should send the form to your insurance carrier. They cannot deny your request for disability benefits solely because your employer failed to fill out their section.

Important to know:

You will receive a response within 18 days of your first day of disability leave or the employer or carrier's receipt of your completed claim, whichever is later. If your claim is rejected, you will receive either a Notice of Denial of Claim for Disability Benefits (Form DB-DEN) or a Notice of Total or Partial Rejection of Claim for Disability Benefits (Form DB-451). If you receive a Form DB-DEN, you will receive a form DB-451 with additional information within 45 days of your first day of disability leave or the employer or carrier's receipt of your completed claim, whichever is later.

If you do not receive a response within 18 days (or the Form DB-451 within 45 days) or if you have questions about your disability benefits claim, please call your employer's insurance carrier. For general information about disability benefits, please visit www.wcb.ny.gov or call the Board's Disability Benefits Bureau at (877) 632-4996.

Notice and Proof of Claim for Disability Benefits (Form DB-450) Instructions

PART A - EMPLOYEE INFORMATION (to be completed by the employee)

You must answer all questions in this part.

Question 9: Enter the best estimate of average gross weekly wage. Fill out the table using your gross wages from your last employer prior to disability. If you had more than one employer in the previous 8 weeks prior to your disability, include all wage information from those employer(s) as well.

Step 1: Add all gross wages received (before any deductions) over the last eight weeks prior to the first day of disability, including overtime and tips earned. (See Step 3 for instructions for calculating bonuses and/or commissions.)

Step 2: Divide the gross wages calculated in step one by eight (or the number of weeks worked if less than eight) to calculate the average weekly wage.

Step 3: If you received bonuses and/or commissions during the 52 weeks preceding the first day of disability, add the prorated weekly amount to the average weekly wage. To determine the prorated weekly amount, add all bonuses/commissions earned in the preceding 52 weeks and then divide by 52.

PART B - HEALTH CARE PROVIDER'S STATEMENT (to be completed by the health care provider)

The health care provider must fill in this statement completely and return it within seven days of receipt of this form.

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

The employer must complete and return to the employee within three business days of receipt.

Question 6: If wages were continued during disability, specify how wages were paid – through salary continuation, use of paid time off, sick time, etc.

Question 8: Enter the wages earned by the employee during the last eight weeks preceding the first day of disability. The gross amount paid is the employee's gross weekly pay, including any overtime and tips earned for that week, plus the weekly prorated amount of any bonus or commission received during the preceding 52 weeks. (For detailed steps, see Question 9 in the Part A instructions). Calculate the gross average weekly wage by adding up the gross amounts paid, and then dividing the total by eight (or number of weeks worked if less than eight).

SHELTERPOINT

New York State

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

Claim Number: _____

PART A - CLAIMANT'S INFORMATION (Please Print or Type)

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

2. Mailing Address (Street & Apt. #): _____

City: _____ State: _____ Zip: _____

3. Daytime Phone #: _____ (Area Code + Phone Number) Email Address: _____

ShelterPoint Disclaimer: By providing your contact information you consent to Us contacting you by any of the methods provided.

4. Social Security #: _____-_____-_____ 5. Date of Birth: _____/_____/_____ 6. Gender: ☐ M ☐ F ☐ X

7. Describe your disability (if injury, also state how, when and where it occurred): _____

_____

8. Date you became disabled: _____/_____/_____ Did you work on that day?: ☐ Yes ☐ No

Have you recovered from this disability?: ☐ Yes ☐ No If Yes, date you were able to return to work: _____/_____/_____

Have you since worked for wages or profit?: ☐ Yes ☐ No If Yes, list dates: _____

9. Name of last employer prior to disability. If more than one employer in previous eight (8) weeks, name all employers. Average Weekly Wage is based on all wages earned in last eight (8) weeks worked.

LAST EMPLOYER(S) PRIOR TO DISABILITY			PERIOD OF EMPLOYMENT		
Firm or Trade Name	**Address**	**Area Code + Phone Number**	**First Day** (MM/DD/YYYY)	**Last Day Worked** (MM/DD/YYYY)	**Average Weekly Wage** (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)

Enter total wages earned in the last 8 weeks prior to the first day of disability below (Include wages for all employers listed above)

Week No.	Last Day Worked (MM/DD/YYYY)	No. of Days Worked	Gross Amount Paid
1			
2			
3			
4			
5			
6			
7			
8			
		Calculated average gross weekly wage:	**$ 0.00**

10. My job is or was: _____ (Occupation) 11. Union Member: ☐ Yes ☐ No If "Yes": _____ (Name of Union or Local Number)

12. Were you claiming or receiving unemployment prior to this disability? ☐ Yes ☐ No

If you did **not** claim or if you claimed but did **not** receive unemployment insurance benefits *after* LAST DAY WORKED, explain reasons fully: _____

_____

If you did receive unemployment benefits, provide all periods collected: _____

Claim Number: _____

PART A - CLAIMANT'S INFORMATION (Please Print or Type)

13. For the period of disability covered by this claim:
A. Are you receiving wages, salary or separation pay? ☐ Yes ☐ No
B. Are you receiving or claiming:
1. Unemployment Benefits? ☐ Yes ☐ No 2. Paid Family Leave? ☐ Yes ☐ No
3. Workers' compensation for work-connected disability? ☐ Yes ☐ No
4. No-Fault motor vehicle accident? ☐ Yes ☐ No **or** personal injury involving third party? ☐ Yes ☐ No
5. Long-term disability benefits under the Federal Social Security Act for *this* disability? ☐ Yes ☐ No

IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 13, COMPLETE THE FOLLOWING:
I have: ☐ received ☐ claimed from: _____ for the period: ____ / ____ / _____ to: ____ / ____ / _____

14. In the year (52 weeks) before your disability began, have you received disability benefits for other periods of disability? ☐ Yes ☐ No
If yes, Paid by: _____ from: ____ / ____ / _____ to: ____ / ____ / _____

15. In the year (52 weeks) before your disability began, have you received Paid Family Leave? ☐ Yes ☐ No
If yes, Paid by: _____ from: ____ / ____ / _____ to: ____ / ____ / _____

16. If you became disabled while employed or within four weeks of your last day worked, did your employer provide you with your rights under Disability Law within 5 days of your notice or request for disability forms? ☐ Yes ☐ No

I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled. I have read the instructions of this form and certify that the foregoing statements, including any accompanying statements are, to the best of my knowledge, true and complete.

_____ _____
Claimant's Signature **Date**

An individual may sign on behalf of the claimant only if they are legally authorized to do so and the claimant is a minor, mentally incompetent or incapacitated. If signed by other than claimant, print information below and complete and submit Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records.

_____ _____ _____
On behalf of Claimant **Address** **Relationship to Claimant**

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. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date in item 7-e. **INCOMPLETE ANSWERS MAY DELAY PAYMENT OF BENEFITS**.

1. Last Name: _____ First Name: _____ MI: ___
2. Gender: ☐ M ☐ F ☐ X 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 medical 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 #**

Policy #:_____ **Claim Number:** _____

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

1. Business's full legal name and mailing address

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: _____
Area Code + Phone 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's role: ☐ Employee ☐ Proprietor ☐ Partner ☐ Spouse of Employer ☐ Owner ☐ Co-Owner

Employee's date of hire (MM/DD/YYYY): _____

Date employee last worked: _____

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

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			
2			
3			
4			
5			
6			
7			
8			
		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: _____

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: _____
Area Code + Phone Number

Date: _____

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.*

Retain a copy of the form for your records and return fully completed claim forms to ShelterPoint by one of the below listed methods:

Fax: 516-504-6414
Mail: ShelterPoint Life, Attn: Claims Dept, 1225 Franklin Ave – Ste 475, Garden City NY 11530
Email: claimforms@shelterpoint.com
Web upload: www.shelterpoint.com

If submitting updates on an existing claim, please include the **claim number** and **claimant first and last name** in the subject line.
For questions regarding claims, including status updates- contact our customer service department at 1-800-365-4999 Monday – Friday during normal business hours .
For copies of claim packages – visit our claims help page at https://info.shelterpoint.com/claim-help

SHELTERPOINT

Supplement to DB450 – Notice and Proof of Claim for Disability Benefits – NY

Claim Number: _____

Overview & Instructions:

This supplemental form is used to obtain additional information from both the Claimant and Employer that were not included on the prescribed DB450 form, but may be required as part of state or federal regulation. Part 1 is for the claimant to complete, to indicate their benefit payment preference. Part 2 is for the Employer to complete, to provide details that will aid in determining the taxation of benefit payments.

Part 1: COMPLETED BY THE CLAIMANT/EMPLOYEE REQUESTING NY DISABILITY BENEFITS

Claimant Last Name:_____ Claimant First Name:_____

SSN/I-Tin: __ __ __ - __ __ - __ __ __ __ Date of Birth: ____ /____ /_____

Benefit Payment Preference for eligible ShelterPoint Disability Claims

Please choose your preference for receiving benefit payments. Certain options may not be available depending on the benefit recipient. If your claim does not qualify for ACH/direct deposit, your benefit payments will automatically be issued via paper check. A completed enrollment form is required to participate in direct deposit. Proof of banking/Account information is needed to establish Direct Deposit (e.g. copy of voided check or letter from bank confirming accountholder name, routing number and account number).

☐ **Paper Check** ☐ **Direct Deposit (ACH)**

Claimant Signature: _____Date signed: ____ /____ /_____

Part 2: COMPLETED BY THE EMPLOYER (ER) FOR THE EMPLOYEE REQUESTING NY DISABILITY BENEFITS.

Employer Name (Business Name): _____

Employer FEIN: __ __ - __ __ __ __ __ __ __ ShelterPoint DBL Policy #: _____

Contributions to Disability Benefit Premiums

Does employee contribute to the costs of state-mandated disability premium?

☐ Yes → dollar amount per week $_____ *or* percentage of contribution _____%

☐ No

Important note: Employee contributions to state-mandated disability benefits may appear on the employee's pay stub as "SDI" or "NY DBL" contribution. The maximum employee contribution for NY DBL is currently set at 0.5% of wages up to a maximum of $0.60 per week. This is a *separate contribution* amount than NY PFL. Please check against payroll records to ensure you are accurately reporting the contribution status and details for employees as it can have tax implications.

If the employee is fully paying the costs to the disability benefits premium, then the employee contributes 100%, and the claim should be non-taxable. If the employee does not contribute, then their claim would be 100% taxable. If the employee contributes a portion to disability benefits premium, then their claim would be partially taxable based on the ratio of employee to employer contributions. **If you leave this section blank we will assume the employee <u>does not</u> contribute.**

Employer Name & Title: _____

Employer Contact Email: _____

Employer Contact Phone #:(_____)_____

Employer Signature:_____ Date Signed: ____ /____ /_____

End of DB450 Supplement

Direct Deposit Enrollment and Authorization Form for New York Disability Benefits Law ("DBL") and Paid Family Leave ("PFL") Claims Payments

INSTRUCTIONS

PLEASE PRINT ALL INFORMATION LEGIBLY. This form must be fully completed, signed, and dated to be valid. Incomplete or ineligible submissions are unable to be processed and will not be accepted.

Eligibility for Direct Deposit: ShelterPoint Life Insurance Company ("Company") offers Direct Deposit Payments for continuous DBL and PFL claims where benefit payments are being issued directly to the claimant/employee.

Direct deposit is not currently available for non-NY coverages, in situations where leave is being claimed intermittently, or where the Company is reimbursing your Employer due to continued payment of wages. As a result, direct deposit will not be implemented in these situations, and direct deposit payments will stop if your claim converts from continuous leave to intermittent leave and any future benefit payments due under the claim will be issued via check. In the event that a direct deposit payment is rejected due to inaccurate banking information, the rejected payment and any future benefit payments due under the claim will be issued via check until the bank information is corrected and an updated Enrollment and Authorization Form is submitted.

Required information: you must supply all requested information on this form. Fully completed, signed and dated forms may be sent to ShelterPoint Life by any one of the below listed methods:

- Submit electronically through our claimant portal
- Email to: claimforms@shelterpoint.com
- Fax to: 516-504-6414
- Mail to: ShelterPoint Life, 1225 Franklin Avenue-Ste 475, Garden City NY 11530

If you have any questions regarding this form, please contact our Customer Service Department at 1-800-365-4999 during normal business hours. **Please allow up to 10 business days for set up of your direct deposit request.**

REQUIRED INFORMATION (please print all information LEGIBLY)

1. **Claimant Name (First name, Last name)**

2. **Social Security Number or I-TIN** (9 digits)

3. **ShelterPoint Life Claim Number(s)**

4. **Account Type**

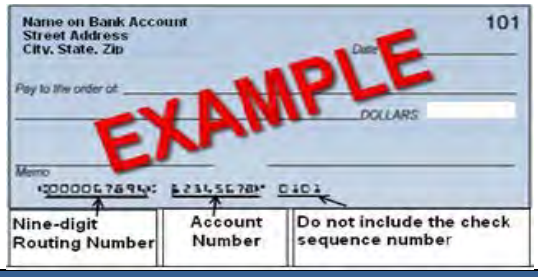
☐ Checking Account ☐ Savings Account

5. **Banking Information**

Bank Name: _____

Bank Routing Number (ABA#):_____

Bank Account Number:_____



AUTHORIZATION AND SIGNATURE

I authorize ShelterPoint Life Insurance Company ("Company") to deposit any benefits I am eligible to receive directly into the bank account I have indicated above or to such other account as the bank or any successor bank designates as my account. I also authorize the Company to debit my account for any deposits made in error, or the Company reserves the right to request the return of such funds through other mechanisms.I also understand that the direct deposit service will stay in effect until I notify the Company in writing of cancellation or until I am no longer eligible for or due payments, whichever comes first. I acknowledge that if I am also covered under another ShelterPoint Disability / Paid Leave policy, this request will also apply to any other current open claim(s) that are eligible for direct deposit, if approved by the Company. I understand that I have the opportunity to view my EOBs and payment history via claims portal registration on shelterpoint.com.

☐ Check this box if you **do not** want to receive paper EOBs in the mail if your direct deposit request is approved.

Claimant Signature	**Date (mm/dd/yyyy)**