Claimant's Name: _____ Social Security #: _____

New York State Workers' Compensation Board, Disability Benefits Bureau
Form DB-450.1, Claimant's Statement Regarding No Fault or Personal Injury

Instructions to Claimant: Complete this form if you became disabled after having been **unemployed for more than four (4) weeks** and you have indicated on Form DB-450 that your disability may be the result of an injury due to a no-fault motor vehicle accident or the negligence or wrong doing of a third party, i.e. individual, firm, etc.

Section 227 of the Disability Benefits Law provides that the Chair of the Workers' Compensation Board can take a lien, in the amount of benefits paid to you, against the proceeds of any recovery you may receive from a third party, whether by judgement, settlement or otherwise.

The Law provides that you may lose your rights to Disability Benefits and may be required to refund payments already made to you, if you:
1. Accept settlement from a third party in an amount less than the benefits provided by the Disability Benefits Law, without the written consent of the Chair of the Workers' Compensation Board.
2. Sign any waiver or release of your claim against a third party, regardless of whether or not you received any payment.

You must complete this form and submit it with your completed DB-450 so that there will be no delay in the payment of your Disability Benefits.

CLAIMANT'S STATEMENT ABOUT ACCIDENT

1. Date of Accident	2. Location of Accident (**Give Complete Address, City, State, Zip**)

3. Cause of Accident: ☐ Motor Vehicle ☐ Workers' Compensation ☐ Other

4. a. Have you commenced action against such party? ☐ Yes ☐ No
b. If "No", do you intend to commence such action? ☐ Yes ☐ No
If "Yes", please provide the name and address of the party (or parties):

5. If you have retained an Attorney, please provide the following information:

Attorney Name and Address	Phone #:

6. Have you received any settlement for injury? ☐ Yes ☐ No
If "Yes", please provide: Amount of Settlement ($) Date of Settlement:

7. Have you received payment for medical care other than from your own insurance or health plan? ☐ Yes ☐ No
If "Yes", please provide Name and Address of Insurance Carrier or other party making payment

Motor Vehicle Accident - Complete this Section and attach MV-104, Report of Accident or Police Report of Accident

8. Are you claiming/receiving or intend to claim/receive No-Fault Insurance Benefits? ☐ Yes ☐ No
Was a commercial vehicle involved: ☐ Yes ☐ No If Yes, are you taking third party action: ☐ Yes ☐ No If "No", please explain.
Explanation:

Damages for Other Personal Injury Involving Third Party

9. Was this party insured for such action? ☐ Yes ☐ No

Name and Address of Insurance Carrier:	Policy #

10. Were you insured for this accident? ☐ Yes ☐ No

If "Yes", please provide Name and Address of Insurance Carrier	Policy #

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge true and complete.

Claimant's Signature: _____ Date: _____

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