SHELTERPOINT

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How to Complete the DB450 Claim Form for DBL

A guide for the Claimant, Healthcare Provider, & Employer

Part A - Claimant's Information

What is the DB450 Claim Form?

The DB450 Claim Form is the initial form used to file a disability benefits claim for individuals who become disabled due to a non work-related illness or injury while employed. The same form is also used within 4 weeks after termination of employment OR if you become disabled after having been unemployed for more than 4 weeks.

To ensure your claim is handled in a timely fashion, it is important that this claim form is legibly filled out in its entirety with all sections completed. **Missing, incomplete, or illegible information will result in a delay in processing your claim.**

Before submitting this Claim Form for processing, be sure each section is **fully completed**. There are 3 sections on the DB450:

- **Part A** is for the **Claimant (Employee)**
- **Part B** is for the **treating Physician/Medical Practitioner**
- **Part C** is for the **Employer.**

Each Part must be fully completed, signed, and dated by the appropriate party.

Be sure to make a copy of the completed Claim Form and retain for your records. A detailed outline of each section is below.

Your privacy and security is important to us - none of your information is distributed to 3rd parties without your express consent.

In this section you will enter your First and Last Name, Social Security Number, Mailing Address and other details which will aid in processing the claim.

All information should be printed & legible.

New York State

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

DB-450 5-19

Read instructions on page 2 carefully to avoid a delay in processing. You must answer all questions in Part A and questions 1 through 3 in Part B. Health care providers must complete Part B on page 2.

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

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

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

City: _____ State: _____ Zip: _____ Country: _____

3. Daytime Phone #: _____ Email Address: _____

4. Social Security #: _____ - _____ - _____ 5. Date of Birth: ___ - ___ - _____ 6. Gender: ☐ Male ☐ Female

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 PRIOR TO DISABILITY			PERIOD OF EMPLOYMENT		**Average Weekly Wage** (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
Firm or Trade Name	Address	Phone Number	First Day	Last Day Worked	
			Mo. Day Yr.	Mo. Day Yr.	
OTHER EMPLOYER (during last eight (8) weeks)			**PERIOD OF EMPLOYMENT**		**Average Weekly Wage** (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
Firm or Trade Name	Address	Phone Number	First Day	Last Day Worked	
			Mo. Day Yr.	Mo. Day Yr.	
			Mo. Day Yr.	Mo. Day Yr.	

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: _____

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. Workers' compensation for work-connected disability: ☐ Yes ☐ No
2. Paid Family Leave: ☐ Yes ☐ No
3. No-Fault motor vehicle accident?: ☐ Yes ☐ No **or** personal injury involving third party?: ☐ Yes ☐ No
4. 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 on page 2 of this form and that the foregoing statements, including any accompanying statements are, to the best of my knowledge, true and complete.

Claimant's Signature | **Date** | **Claimant's email address**

An individual may sign on behalf of the claimant only if he or she is 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 A - Claimant's Information

Question 1:
PRINT your last name and first name in the space provided.

Question 2:
PRINT your current mailing address (Street # and name, apartment #, City, State, Zip). We will use the address provided when mailing correspondence and/or benefit checks to you. An incomplete or incorrect address could result in returned or lost mail and delay in processing your claim.

Question 3 – Daytime Phone # and email address:
This is the contact phone and email address where we may reach you, should there be any questions on your claim.

Question 4 – Social Security #:
Enter your nine digit social security number in the boxes provided. This information is required for tax reporting purposes. If you have an I-TIN instead of a SSN; provide your I-TIN.

Question 5 – Date of Birth:
Enter the month, day, and year in which you were born.

Question 6 – Gender:
Select your gender (Male or Female).

Question 7:
Enter a brief description of your disability. If you were injured, please also provide details on when (date) and where (location of incident) the incident occurred, as well as how you came to be injured.

Question 8:
Enter the date you became disabled, whether or not you worked on that day, whether you have recovered from this disability (and if so, the date you were able to work), and if you have since worked for wages. If you have since worked for wages, provide dates.

Question 9:
Enter your **Employer's information**, including business name, address, phone #, dates employed (when you started working through your last day worked prior to the disability) and your average weekly wages.

IMPORTANT: If you have more than one job, be sure to complete for ALL employers. Each employer will need to complete their own Part C.

Question 10:
Tell us your job title.

Question 11:
If you are a member of a union that **provides DBL benefits to its members**, please enter the union name and local number.

Question 12:
Indicate whether you are claiming or receiving unemployment benefits prior to this disability: (Check Yes or No where applicable). If you didn't claim or if you claimed but didn't receive unemployment benefits after your last day worked, provide detail in the space provided.

Part A - Claimant's Information

Question 13 – For the period of disability covered by this claim:

a) Have you received any wages, salary, or separation pay? If so, enter YES, and specify whether you have received, or claimed for, and the date range. If your wages have ceased, enter NO.

b) Are you receiving or claiming: (Check Yes or No where applicable)

(1) Workers compensation for work-connected disability
(2) Paid Family Leave
(3) No-Fault motor vehicle accident or personal injury involving third party
(4) Long-term disability benefits under the Federal Social Security Act for this disability

*If you have marked YES to any of the options in question 13, you must also provide additional detail regarding the period of time in which you are receiving or claiming these benefits. *

Question 14:

Answer Yes or No to the question "in the year (52 weeks) **before** your disability began, have you received disability benefits for other periods of disability?". If yes, provide from whom the benefit was collected, and the period of time during which you received benefits.

Question 15:

Answer Yes or No to the question "in the year (52 weeks) **before** your disability began, have you received Paid Family Leave". If yes, provide from whom the benefit was collected, and the period of time during which you received benefits.

Question 16:

Answer Yes or No to the question "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?"

Part A must be signed by claimant and/or authorized representative. End of Part A.

Part B - Healthcare Provider's Statement

Instructions for the Claimant:

This section must be completed by your treating Healthcare provider or Practitioner, providing all details of your disabling condition. Be sure all questions are answered, the information is legible, and your provider/practitioner has signed and dated Part B. This section must be completed, signed and dated **AFTER** the date you became disabled and stopped working.

Be sure your form is completed and signed by an authorized practitioner.

Please be advised **the following medical professionals are NOT authorized** to complete and sign part B of the DB450 form:

- RN (Registered Nurse)
- CSW (Certified Social Worker)
- PT (Physical Therapist)
- LPN (Licensed Practical Nurse)

Instructions for the Health Care Provider:

IMPORTANT: Part B must be fully and legibly completed to process the claim in a timely fashion. In addition to providing the medical details necessary to examine the claim, **this statement MUST be signed by the treating practitioner and dated to be considered acceptable.**

You must select the appropriate professional degree, enter your license number and state in which you are licensed to practice. Finally, we must have your practice name and mailing address in case additional medical documentation is required.

Part B - Healthcare Provider's Statement

PART B - HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type)

T**HE 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.** For item 7-d, you must give estimated date. 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: ☐ Male ☐ Female 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 Form C-4 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 #**

IMPORTANT NOTICE TO CLAIMANT- READ THESE INSTRUCTIONS CAREFULLY

PLEASE NOTE: Do not date and file this form prior to your first date of disability. In order for your claim to be processed, Parts A and B must be completed.

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 mailed **within thirty (30) days 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**, your completed claim should be mailed to: **Workers' Compensation Board, Disability Benefits Bureau, PO Box 9029, Endicott, NY 13761-9029.** If you answered "Yes" to question 13.B.3, please complete and attach Form DB-450.1.

If you do not receive a response 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.

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, "Claimant's 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 or visit our nearest Customer Service Center to obtain a copy of the form. In lieu of Form OC-110A, you may also submit an original signed, notarized authorization letter.

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.

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Part B - Healthcare Provider's Statement

All information should be printed & legible. Incomplete answers may delay payment of benefits.

Question 1:
Please PRINT the claimant's (Patient) Last Name and First Name.

Question 2– Gender:
Please indicate whether the claimant is Male or Female.

Question 3–Date of Birth:
Please enter the claimant's date of birth (month, day, year).

Question 4– Diagnosis/Analysis:
Please indicate the symptoms and findings of the claimant's disabling condition. Be sure to include any complications which may have exacerbated the disabling condition and provide applicable diagnosis codes if possible.
If this is a pregnancy claim, please enter the estimated date of delivery in this section.
If claimant has already delivered, please provide actual delivery date and type.

Question 5:
Please indicate if the claimant was hospitalized. If hospitalized, provide the confinement dates (from/to).

Question 6:
Please indicate whether or not an operation was performed. If yes, provide type of surgery and the date it took place.

Question 7:

IMPORTANT: YOU MUST PROVIDE DATES for questions 7A through 7D.

a) Date of claimant's **FIRST (Initial)** treatment for their disability (print date in Month, Day, Year format in the boxes provided)
b) Date of claimant's **MOST RECENT** treatment for their disability (print date in Month, Day, Year format in the boxes provided)
c) Date claimant was medically **UNABLE TO WORK (ONSET DATE)** due to this disability (print date in Month, Day, Year format in the boxes provided). This is not necessarily a working day, but the actual day that you certified the claimant disabled.
d) Date claimant will be again be able to perform work **(PROGNOSIS)** (print date in Month, Day, Year format in the boxes provided). **DO NOT LEAVE THIS FIELD BLANK OR ENTER "TBD/UNDETERMINED".** You may estimate a prognosis date based on the claimant's current condition and taking into consideration all applicable diagnoses. If claimant will never be able to work again due to their disability, please specify.
e) If pregnancy related, please check box (estimated delivery date or actual delivery date) and enter the date.

Question 8:
Please indicate whether or not this disabling condition may be WORK RELATED.
If Yes, indicate whether a C-4 Doctor's Initial Report has been filed with the Workers' Compensation Board.

Practitioner Information (Type of Practitioner, License State, License #, Signature, Date, Practice Name, Mailing address etc). **Please legibly print all information.**

End of Part B.

Part C - Employer's Statement

Instructions For the Claimant:

In this section **your employer** will provide details of your employment. Be sure all questions are answered, the information is legible, and your employer has signed and dated Part C.

If you have more than 1 employer, be sure **each** employer completes their own Part C, and all pages are included with your claim submission.

If you are self-employed, your bookkeeper or accountant must complete this form on your behalf. You may be asked to provide copies of your K-1 or 1040 schedule C.

Instructions For the Employer:

Part C must be **fully and legibly** completed to process the claim in a timely fashion. In addition to providing the employee's details of their employment necessary to examine the claim, **this statement MUST be signed, titled, and dated to be considered acceptable**. We must also have your business name and mailing address in case additional information is required.

PART C- EMPLOYER'S STATEMENT

Instructions: Complete this form in its entirety for your employee claiming disability benefits. Any missing or incomplete information could result in delays processing their claim.

1. Employee's full name: _____
2. Employee's Social Security Number:___ ___ ___ - ___ ___- ___ ___ ___ ___ Age: _____
3. Their occupation:_____
4. Their role: □ Employee □ Proprietor □ Partner □ Spouse of Employer □ Owner □ Co-owner
5. Date they last worked: ____/____/_____ 5.1Date they returned to work: ____/____/_____
6. Date employee's wages ceased: ____/____/_____
7. Were wages continued during disability? □ Yes □ No Date/Type: _____
   Note: If wages continued were a result of the employee using accrued sick time, vacation time, or paid time off, please indicate the type and date used, and attach to this sheet.
8. If wages were continued, is reimbursement requested to the employer? □ Yes □ No
   Note: Employers may only be reimbursed if the employee used sick time, or if you continued their salary during leave.
9. Is the disability due to their job (work-related)? □ Yes □ No
10. Is the employee a member of a union that provides NYS disability benefits? □ Yes □ No
    if yes, please provide Union name and address:

11. Provide a breakdown of this employee's 8 weeks wages immediately **PRIOR** to their disability, starting with the week the disability began.

Date	# of Days Worked	Amount (gross wages) *wages includes tips, value of board/lodging, and commissions*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
	Total:	

12. Employee's date of hire: _____/____/_____
13. Status: □ Full-time □ Part-time
14. Is employee a full-time High School Student?
    □ Yes □ No
15. Days usually worked:
    □ Mon □ Tue □ Wed □ Thu □ Fri □ Sat □ Sun
16. Does employee contribute to their disability premium?
    □ Yes:_____ □ No
    if yes, please specify dollar amount or specific percentage. If you leave this question blank we will assume they do not contribute.
17. Does employee work for anyone else besides your company?
    □ Yes □ No
18. Has employee made a claim for disability benefits or paid family leave within the past 52 weeks prior to the date this disability began? □ Yes □ No *If yes, please provide details below:*
    Disability Benefits: from _____/____/_____ to _____/____/_____
    Paid Family Leave: from _____/____/_____ to _____/____/_____
19. If this employee received unemployment benefits, date the benefit was last received? _____/____/_____
20. If this employee is no longer in your employment, select reason: □ labor dispute □ lack of work □ discharged □ resigned
    Please provide detail:

Business name (including any DBA/trade name):

Business address:

I have read and acknowledge the fraud warning in the instructions on page 2 of the DB450 form.

Signature:_____ Title: _____

Phone: (_____)_____ Date: _____/_____/_____

Email: _____ Policy Number:_____

Return completed claim form (including Parts A and B) to ShelterPoint Life one of 3 ways:
Fax: 516-504-6414 **Email:** claimforms@shelterpoint.com **Mail:** ShelterPoint, 1225 Franklin Ave-Ste. 475, Garden City, NY 11530

Part C - Employer's Statement

PLEASE NOTE:

Part C cannot be completed or signed by the claimant. If you (the claimant) are the owner/proprietor, the employer's statement must be completed and signed by a bookkeeper or accountant, and additional support of wages may be requested (ex. 1040 Schedule C, K-1, W-2, or paystubs).

Question 1:
Please print the employee's full name.

Question 2:
Provide the employee's 9 digit social security number and age.

Question 4:
Please provide the employee's role in the company.

Question 3:
Please provide the employee's job title.

Question 5:
Please enter the exact date the employee last worked (print date in Month, Day, Year format).

5.1: If the employee has already returned to work, please enter the date the employee returned to work.

Question 6:
Please enter the exact date the employee's wages ceased. If wages are still being continued, enter "N/A". You will reaffirm this in question 7.

Question 7:
Please indicate if wages were continued during disability (Respond with YES or NO). Note, if wages were continued, we will need to know the type of wages (Sick Time, Vacation Time, PTO) and dates collected. You can provide a breakdown on a separate piece of paper to be submitted at same time.

Question 8:
Please indicate whether or not YOUR BUSINESS is requesting reimbursement for continued wages (sick time only).

Question 9:
Please indicate if the employee's disability is work related (respond with Yes or No).

Question 10:
Please indicate if the employee is a member of a union that provides NYS Disability benefits (respond with Yes or No). If yes, provide the Union Name and Number.

Question 11- Wages Grid:
Please provide the employee's 8 weeks of GROSS (pre-tax) wages immediately prior to becoming disabled. You may also submit the same information as a separate page. NOTE: If payroll is bi-weekly, only 4 pay periods should be listed.

If this employee receives additional remuneration in the form of tips, board, lodging, or rent, include the average weekly amount in the reported wages.

Part C - Employer's Statement

Question 12:
Provide the employee's date of hire.

Question 13:
Confirm the employee's status (full time or part time)

Question 14:
Confirm if employee is currently a Full-time High School student.

Question 15:
Select boxes indicating which days of the week the employee normally works. If the employee's schedule varies, provide average days worked per week.

Question 16:
Indicate whether the employee contributes to disability premium or not. (Respond with Yes or No). If yes, indicate the dollar amount of weekly contribution, or percentage of premium the employee contributes. If you do not provide this information we will assume they do not contribute.

Question 17:
Indicate whether the employee works for anyone other than you. This is important as liability may be split amongst multiple employers. If you know the name and address of the other employer, please provide.

Question 18:
Indicate whether the claimant has received or claimed Disability Benefits or Paid Family Leave benefits within the past 52 weeks. If yes, please provide dates of claims.

Question 19:
Enter the last date the employee received unemployment benefits, if applicable.

Question 20:
If the employee no longer works for you, indicate **why** (check the applicable box) and provide detail on their termination/separation.

Additional Required Info on Part C:

Business Name:
Print your Business name here.

Business Address:
Print your Business's mailing address here.

Signature:
Sign your name here.

Title:
Print your job title here.

Phone:
Enter your phone number here, including area code.

Date:
Enter the date you received and completed the form here.

Email:
Provide a contact email.

Part C - Employer's Statement

Additional Required Info on Part C:

Policy Number:
Enter your current ShelterPoint Life Disability Benefits policy #. If you are completing this form as a concurrent employer, and are insured with another Carrier, you can enter your disability policy # and insurance carrier's name here.

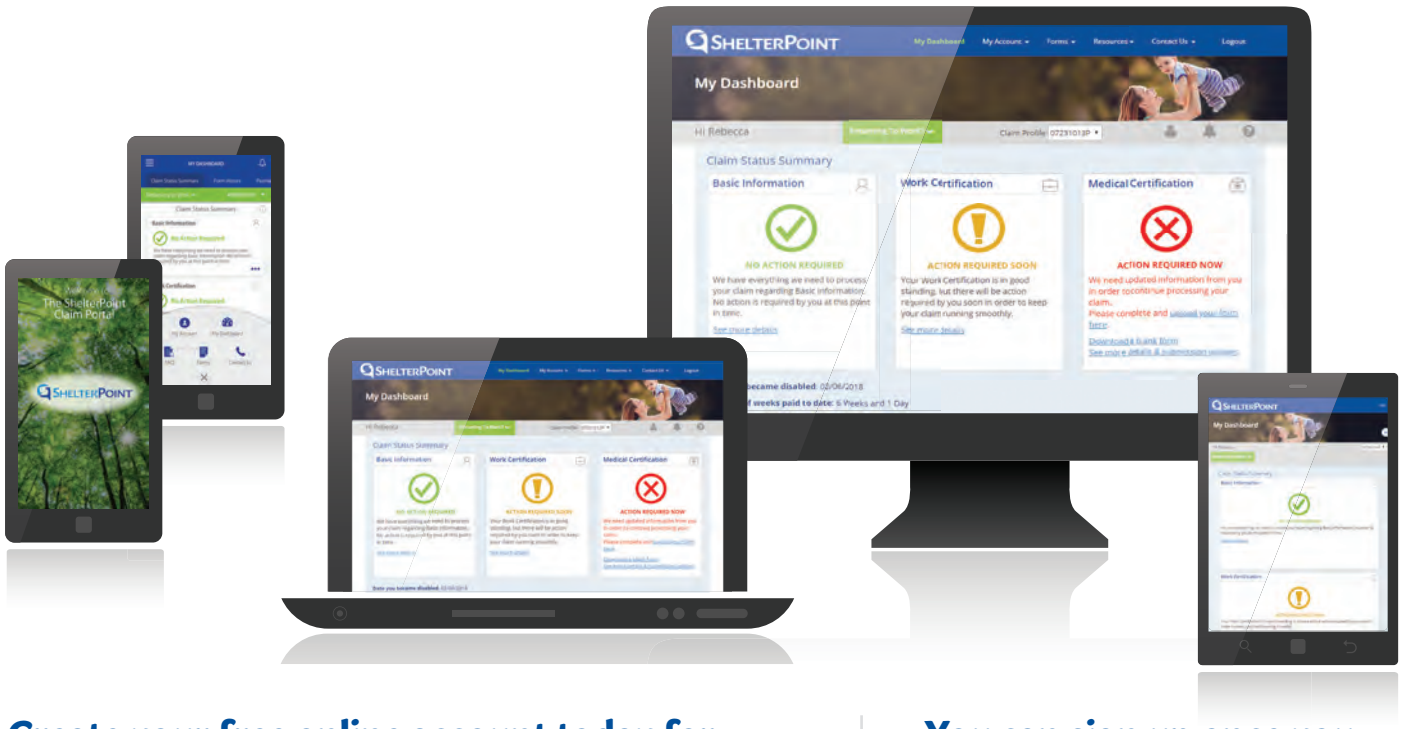
End of Part C.

Once the DB450 form is fully completed, make a copy for your records, and submit one copy to ShelterPoint for processing. The completed claim should be mailed within 30 days of becoming disabled.

Disability Benefits Claims Division:
Email: claimforms@shelterpoint.com
Fax: 516-504-6414
Mail: ShelterPoint Life, 1225 Franklin Ave, Ste 475, Garden City, NY 11530.

Questions?
customerservice@shelterpoint.com or 800.365.4999

Manage your claim 24/7!



Create your free online account today for around-the-clock access to:

- Find out if you are eligible for benefit payments
- View your **current claim status** and see if they need to take any action to assure continued processing of their claim
- Upload forms
- **See when your next check will be sent (DBL only)**
- Check the **history of the benefit payments** we've issued
- See which forms we sent and which forms we've received
- See **important notifications** regarding their claim
- Sign up for **alerts via email when you need to take action**
- Sign up to receive **claim forms electronically**
- Easily toggle between your DBL & PFL claims

...and much more!

Sign up and start managing your claim today!

www.shelterpoint.com/ClaimPortal

You can sign up once you receive your claim number.

Registration is fast and easy – you just need your:

1. Claim number
2. Social Security Number
3. Valid email address

ShelterPoint Claim Portal now available as a mobile app!

Search "ShelterPoint Claims" to download the app.

Download on the App Store

GET IT ON Google Play

App Advantages:

- Snap a picture of your form and upload it. It gets to our claim examiners immediately
- Get push notifications on your home screen

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