Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division

Workers Compensation State Claim Kit

New York

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

AM BEST A++ Superior

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Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

AM BEST A++ Superior

P.O. Box 881236 San Francisco, CA 94188
(888) 495-8949
bhhc.com

Dear Policyholder:

Thank you for placing your workers compensation coverage with Berkshire Hathaway Homestate Companies (BHHC). We look forward to working with you to fulfill all your workers compensation needs.

Enclosed you will find documentation necessary for the processing and administration of a claim in the event of a workplace injury, as well as important information regarding workers compensation requirements for your state (i.e. posting notices, compliance laws, etc). Please utilize the documents included to collect valid information regarding the injured employee and incident, and send the documents in when reporting the claim or upon request. Any completed document should be sent directly to BHHC using mail, e-mail, or fax. The assigned claims professional will forward necessary documentation onto the appropriate state entity.

It is critical that you promptly report all new claims using one of the contact methods listed to the right.

New York state law recommends employers report every industrial injury or occupational disease claim to their workers compensation carrier as soon as possible or within five days of employer knowledge of injury.

State law also requires that employers authorize initial medical treatment within 24 hours of knowledge that an occupational injury of illness has been sustained or reported, regardless of the legitimacy of the claim. Failure to comply may result in the loss of "medical control" and a significant increase in the potential claim cost.

We will attempt to contact you and the injured worker within 24 hours of receiving the First Report of Injury. Your cooperation in allowing the injured employee to speak with one of our Claims Professionals is appreciated.

Should you have any questions regarding the contents of this kit, a claim, or claim reporting, please contact our Customer Care Center at (888) 495-8949. Questions regarding your insurance policy or coverage should be directed to your broker or agent. We thank you for choosing BHHC as your workers compensation carrier and look forward to providing you superior customer service and compassionate care for your injured workers.

BERKSHIRE HATHAWAY HOMESTATE COMPANIES

Contact Information

Online

bhhc.com/workers-compensation/claim-center/report-a-claim.aspx

Phone

(800) 661-6029

Fax

(800) 661-6984

E-mail

newclaim@bhhc.com

Representing Financial Strength & Integrity • Workers Compensation Division

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

AM BEST A++ Superior

Workers Compensation Posting Requirements

Form C-105 – Notice of Compliance – Workers' Compensation Law

- Post in one or more conspicuous places at all business locations
- Print on letter sized (8.5" x 11") paper

To complete the form, please enter the following information in the spaces provided:

- Your company name
- Name of your designated insurance carrier
- Your policy number and policy effective dates (start and end)

For your convenience, our other contact information has been entered on the Poster.

(New York Workers' Compensation Law § 51)

Form C-105.1 – Notice to be Posted by Employer Under NY WCL Section 51 for Automotive or Horse-Drawn Vehicles

Please note, this posting is only required for the following:

1. Employers that own or operate automotive or horse-drawn vehicles with no minimum staff of regular employees required to report for work at an established place of business maintained by such employer.
2. Every employer engaged in the business of moving household goods or furniture.
   - Post in one or more conspicuous places within each company vehicle
   - Print on white 6" x 4" index card or ledger

To complete the form, please enter the following information in the spaces provided:

- Your company name and a signature of a company representative
- Your designed insurance company/carrier name
- Your policy number and policy effective dates (start and end)

For your convenience, our other contact information has been entered on the Poster.

(New York Workers' Compensation Law § 51)

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD
ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

NOTICE OF COMPLIANCE

TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company, which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Line: 877-632-4996

AVISO DE CUMPLIMIENTO

A EMPLEADOS

INFORMACION IMPORTANTE PARA EMPLEADOS QUE SEAN LESIONADOS O SUFRAN UNA ENFERMEDAD OCUPACIONAL MIENTRAS TRABAJAN.

1. Su patrono está cumpliendo la Ley de Compensación Obrera cuando despliega este comunicado concerniente a sus derechos como trabajador lesionado.
2. Si usted no notifica a su patrono dentro del término de 30 dias de haber sufrido su lesión su reclamación podría ser desestimada, por eso notifique inmediatamente.
3. Usted tiene derecho a recibir cualquier tratamiento médico necesario relacionado con su lesión y debe gestionarlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obtener tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en cualquiera de estos programas establecidos por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
6. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de siete días, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo.
7. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podría ser responsable del pago de las facturas.
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague al abogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene dificultad en conseguir un formulario de reclamación o necesita ayuda para llenarlo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuniquese con la oficina mas cercana de la Junta.

CHAIR/PRESIDENTE
Workers' Compensation Board

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensación Obrera, cuando debidos, seran pagados por):

Insurance Carrier Name -
Address - PO BOX 881716, San Francisco, CA 94188
Phone- (800) 661-6029 Fax - (415) 675-546

For Insurance Carriers ONLY: Policy No.....

Policy in Force from .....to .....

Name of employer (Nombre del patrono)

.....

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

STATE OF NEW YORK - WORKERS" COMPENSATION BOARD
纽约州劳工赔偿局

NOTICE OF COMPLIANCE
TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

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3. You are entitled to obtain any necessary medical treatment and should do so immediately.
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8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

合规公告
致员工

致受工伤或患职业病雇员的重要信息。

1. 通过张贴本公告以及关于受伤雇员所享权利的信息，雇主将遵循《劳工赔偿法》的规定。
2. 如果您未在受伤之后的 30 天内通知雇主，则您的索赔请求可能被驳回，因此请立即通知您的雇主。
3. 您有权获得任何必要的医疗照护，并应立即这样做。
4. 您可以选择接收纽约州劳工赔偿的患者且经劳工赔偿局授权的医生转介的任何医生、足科医生、按摩师或心理医生。然而，如果您的雇主参与了认证优选医疗服务组织 (PPO) 计划，您必须从雇主选择的医疗服务提供者处接受治疗，并且雇主必须向您开具书面声明，说明您进一步享有医疗服务的权利。
5. 您应告知医生，向劳工赔偿局和雇主的保险公司提交与您的索赔相关的医疗报告副本，邮寄地址见此表底部。
6. 如果工伤导致您误工超过七天，迫使您选择低工资工种，或者导致您任何身体部位永久残疾，您有权享受误工补偿。如果需要帮助以返回工作岗位，您可以享受复健服务。
7. 您不应直接向医疗服务提供者支付医疗费用。他们应该将账单寄给雇主的保险公司。如有争议，医疗服务提供者必须等到本局作出裁决之后，才可向您收取费用。如果您放弃索赔或者本局裁定您的伤害与工作无关，您则需要支付医疗费用。
8. 您有权选择律师或持牌代理作为您的代理人，但这不是必须的。如果您确实雇用了一名代理，请不要直接向其支付费用。所有费用均由本局决定，并从您获得的赔偿款中扣除。
9. 如果您不方便领取索赔申请表或在填写时需要帮助，或是您对工伤有任何其他问题，请联系劳工赔偿局办公室。

Robert E. Beloten

ROBERT E. BELOTEN, CHAIR/主席

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5202

Statewide Fax/全州传真：877-533-0337

Workers' Compensation benefits, when due, will be paid by: (劳工赔偿补贴到期时将由以下方支付：)

Name, address and telephone number of licensed insurance carrier, authorized grop selfisurer or main office of authorized self-insurer (持牌保险公司、授权自我投保人的名称、地址和电话号码或者授权自我投保人的主要办公室)

Insurance Carrier Name -
Address - PO Box 881716, San Francisco, CA 94188
Phone - 800-661-6029 Fax - 415-675-5469

For Insurance Carriers ONLY: Policy No.
(仅针对保险公司： 保险单编号) .....

Policy in Force from *..to.*
(保险单有效期从) *(至)*

Name of employer (雇主名称)

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

(本公告必须张贴于雇主所在地点或办公地点内部及周围显眼的地方。)

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

(如果雇主未将本公告张贴于雇主所在地点或办公地点内部及周围显眼的地方，则每次违规行为可能导致 250 美元的罚款。)

C-105C (10-12) Workers' Compensation Board
Prescribed of by Chairman
State New York
www.wcb.ny.gov

STATE OF NEW YORK - WORKERS" COMPENSATION BOARD
뉴욕주 - 근로자재해보상위원회

NOTICE OF COMPLIANCE
TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company, which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5202

Statewide Fax/전주 팩스 번호: 877-533-0337

준수 통지서
직원에게

작업중 부상을 당하거나 직업병에 걸린 직원들을 위한 중요 정보.

1. 부상 당한 근로자로서 귀하의 권리에 관한 이 통지서 및 정보를 게시함으로써 귀하의 고용주는 근로자 재해보상 법률을 준수하는 것입니다.
2. 귀하의 부상일로부터 30일 이내에 귀하의 고용주에게 통보하지 않으면 귀하의 청구가 기각될 수 있으므로 즉시 통보하십시오.
3. 귀하는 필요한 의학적 치료를 받을 권리가 있으므로 즉시 그렇게 해야 합니다.
4. 귀하는 의사가 의뢰하고 뉴욕주 근로자 재해보상 환자를 받으며 본 위원회에 의해 승인된 의사, 발전문가, 지압요법사 또는 심리사를 선택할 수 있습니다. 그러나, 귀하의 고용주가 인증된 선호 의료제공자 조직(PPO)에 참여하고 있는 경우, 귀하는 귀하의 고용주가 선택한 의료 제공자로부터 먼저 치료를 받아야 하며 귀하의 고용주는 추가 의료에 관한 귀하의 권리에 대한 설명서를 귀하에게 제공해야 합니다.
5. 귀하는 귀하의 청구에 관한 의료 보고서 사본을 근로자 재해보상 위원회와 귀하 고용주의 보험회사에 제출하도록 귀하의 의사에게 말해야 합니다(연락처는 이 양식 하단에 표시되어 있음).
6. 귀하는 작업 관련 부상으로 인해 8일 이상 출근할 수 없거나 더 낮은 임금으로 근무해야 하거나 또는 신체 어느 부위가 영구 장애가 되는 경우 시간 상실 급여를 받을 권리가 있을 수 있습니다. 직장에 복귀하는 데 도움이 필요한 경우 귀하는 재활 서비스를 받을 권리가 있을 수 있습니다.
7. 귀하는 의료 제공자에게 직접 지불해서는 안 됩니다. 의료 제공자는 청구서를 귀하 고용주의 보험회사에 보내야 합니다. 분쟁이 있는 경우, 의료 제공자는 귀하로부터 지불금을 징수하려고 시도하기 전에 본 위원회가 결정할 때까지 기다려야 합니다. 귀하가 청구를 추구하지 않거나 본 위원회가 귀하의 부상이 작업 관련이 아니라고 판정하는 경우 귀하는 청구서를 결제할 책임이 있을 수 있습니다.
8. 귀하는 변호사 또는 면허된 대리인에 의해 대리될 권리가 있습니다만 그것이 요구되는 것은 아닙니다. 귀하가 대리인을 고용하는 경우 그에게 직접 지불하지 마십시오. 수수료는 본 위원회에 의해 결정되고 귀하의 판정액에서 공제될 것입니다.
9. 청구서 양식을 얻는데 어려움이 있거나 작성에 도움이 필요한 경우, 또는 직무 관련 부상에 대한 다른 질문 또는 문제가 있는 경우에는 근로자 재해보상 위원회의 사무소에 연락하십시오.

Robert E. Beloten

ROBERT E. BELOTEN, CHAIR/의장

Workers' Compensation benefits, when due, will be paid by: (기한이 된 근로자 재해보상 급여의 지급처:)

Name, address and telephone number of licensed insurance carrier, authorized group

Insurance Carrier Name -
Address - PO Box 881716, San Francisco, CA 94188
Phone - 800-661-6029 Fax - 415-675-5469

For Insurance Carriers ONLY: Policy No. (보험회사 사용란: 보험증서 번호) .....

.....

Policy in Force from.....*to*.....
(보험증서 유효 기간) *(~)*

Name of employer (고용주의 이름)

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

(이 통지서는 고용주의 장소 또는 사업장 및 그 주변에 눈에 띄게 게시되어야 합니다).

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

(고용주가 이 통지서를 고용주의 장소 또는 사업장 및 그 주변에 게시하지 않으면 각 위반에 대해 $250 벌금에 처해질 수 있습니다).

STATE OF NEW YORK - WORKERS" COMPENSATION BOARD
ETA NEW YORK - KOMISYON KONPANSASYON TRAVAYÈ

NOTICE OF COMPLIANCE
TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

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NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5202

Statewide Fax/Faks Eta a: 877-533-0337

AVI KONFÒMITE
POU ANPLWAYE YO

ENFÒMASYON ENPÒTAN POU ANPLWAYE KI PRAN CHÒK OSWA KI GEN MALADI NAN TRAVAY PANDAN Y AP TRAVAY

1. Lè patwon ou afiche avi sa a ak enfòmasyon konsènan dwa ou kòm yon travayè ki pran chòk, li konfòme li avèk Lwa sou Konpansasyon Travayè.
2. Si ou pa fè patwon ou konnen ou pran yon chòk nan 30 jou ki vini apre dat ou pran chòk la, ou ka jwenn refi pou reklamasyon ou, kidonk fè sa imedyatman.
3. Ou gen dwa pou jwenn nenpòt tretman medikal ki nesesè, epi ou ta dwe jwenn tretman medikal la imedyatman.
4. Ou ka chwazi nenpòt doktè, podyat, kiwopraktè oswa sikològ sou rekòmandasyon yon doktè ki aksepte pasyan Konpansasyon Travayè Eta New York, epi ki gen otorizasyon Komisyon an. Men, si patwon ou konsène nan yon òganizasyon founisè swen sante prefere (PPO) ki sètifye, ou fèt pou jwenn tretman yon founisè swen sante patwon ou chwazi, epitou patwon ou fèt pou ba ou yon deklarasyon alekri sou dwa ou konsènan swen medikal pidevan.
5. Ou ta dwe mande doktè ou pou li depoze kopi rapò medikal konsènan reklamasyon ou nan biwo Komisyon Konpansasyon Travayè epi nan konpayi asirans patwon ou, ki endike anba fòm sa a.
6. Ou ka gen dwa pou jwenn avantaj pou tan ou pèdi si chòk ou pran nan travay ou anpeche ou travay pandan plis pase sèt (7) jou, si chòk la oblije ou travay pou pi piti salè, oswa si chòk la lakòz ou andikape nèt nan nenpòt pati kò ou. Ou ka gen dwa pou jwenn sèvis reyabilitasyon si ou bezwen èd pou retounen travay.
7. Ou pa ta dwe peye okenn founisè swen sante dirèkteman. Yo ta dwe voye bòdwo yo ba konpayi asirans patwon ou. Si gen yon konfli, founisè swen sante a fèt pou rete tann jouk lè Komisyon an pran yon desizyon anvan li eseye touche peman an nan men ou. Si ou pa ale nan lajistis pou reklamasyon ou, oswa si Komisyon an deside chòk ou pa asosye avèk travay ou, ou ka responsab pou peye bòdwo yo.
8. Ou gen dwa pou yon avoka oswa yon reprezantan ki gen lisans reprezante ou, men li pa obligatwa. Si ou anboche yon reprezantan, pa peye li dirèkteman. Se Komisyon an k ap fikse nenpòt frè pou ou peye, epi y ap retire frè pou peye a nan lajan dedomajman ou.
9. Si ou gen pwoblèm pou jwenn yon fòm reklamasyon, oswa si ou bezwen èd pou ranpli fòm nan, oswa si ou gen nenpòt lòt kesyon oswa pwoblèm konsènan yon chòk ou pran nan travay ou, kontakte nenpòt biwo Komisyon Konpansasyon Travayè.

Robert E. Beloten

ROBERT E. BELOTEN, CHAIR/PREZIDAN

Workers' Compensation benefits, when due, will be paid by: (Y ap peye avantaj Konpansasyon Travayè, lè ou dwe resevwa li, selon:)

Name, address and telephone number of licensed insurance carrier, authorized grop selfisurer or main office of authorized self-insurer (Non, adrès ak nimewo telefòn konpayi asirans ki gen lisans, asirans an gwoup ou ki otorize, oswa biwo prensipal asirans ou ki otorize)

Insurance Carrier Name -
Address - PO Box 881716, San Francisco, CA 94188
Phone - 800-661-6029 Fax - 415-675-5469

For Insurance Carriers ONLY: Policy No. (Pou Konpayi Asirans yo SÈLMAN: Nimewo Kontra)

Policy in Force from .... *to*
(Kontra Anvigè ant) (*ak*)

Name of employer (Non patwon)

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

(YO FÈT POU AFICHE AVI SA A AKLÈ ANDEDAN AK NAN ZÒN LOKAL PATWON AN OSWA LOKAL BIZNIS YO)

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.
(Si yon patwon pa afiche avi sa a andedan ak nan zòn lokal patwon an oswa lokal biznis yo sa ka lakòz patwon an peye yon amann $250 pou chak vyolasyon.)

STATE OF NEW YORK - WORKERS'' COMPENSATION BOARD
STATO DI NEW YORK- WORKERS' COMPENSATION BOARD

NOTICE OF COMPLIANCE
TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company, which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

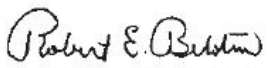
NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5202

Statewide Fax/Linea fax valida su tutto il territorio dello Stato: 877-533-0337

INFORMATIVA DI CONFORMITÀ
AI DIPENDENTI

INFORMAZIONI IMPORTANTI PER I DIPENDENTI VITTIME DI INFORTUNIO O CHE SOFFRONO DI MALATTIA CORRELATA ALLA PROFESSIONE.

1. Esponendo la presente informativa e le informazioni in merito ai Suoi diritti in quanto lavoratore infortunato, il Suo datore di lavoro agisce conformemente a quanto stabilito dalla Workers' Compensation Law.
2. Non notificando l'infortunio al datore di lavoro entro 30 giorni dallo stesso, la Sua richiesta potrebbe essere respinta. Si consiglia, quindi, di presentarla in modo tempestivo.
3. Lei ha diritto a ricevere qualsiasi tipo di trattamento medico necessario. Si consiglia, quindi, di provvedere immediatamente a tal proposito.
4. Sarà possibile rivolgersi, su segnalazione del medico autorizzato, a qualsiasi medico, podologo, chiropratico o psicologo autorizzato dalla Workers' Compensation Board che accetti di curare pazienti coperti da assicurazione sul lavoro dello Stato di New York. Tuttavia, nel caso in cui il proprio datore di lavoro faccia parte di un'organizzazione di prestatori di assistenza sanitaria convenzionati (PPO), si dovrà ricevere il trattamento iniziale da parte del membro di tale organizzazione deputato dal Suo datore di lavoro a fornire assistenza medica. Il Suo datore di lavoro, quindi, Le dovrà fornire dichirazione scritta dei Suoi diritti relativi a cure mediche extra.
5. Dovrebbe chiedere al Suo medico di inviare le copie dei referti medici relativi alla Sua richiesta alla Workers' Compensation Board e alla compagnia assicurativa del Suo datore di lavoro, che è indicata in calce al modulo.
6. Potrebbe beneficiare di un'indennità per la perdita di giornate lavorative qualora l'infortunio non consenta di andare al lavoro per oltre sette giorni, obblighi a lavorare per una retribuzione minore o comporti una disabilità permanente a qualsiasi parte del corpo. Potrebbe beneficiare dei servizi di riabilitazione al fine di agevolarne nel reinserimento lavorativo.
7. Non dovrà sostenere direttamente alcun tipo di spesa medica. Le ricevute delle spese mediche dovranno essere inviate alla compagnia assicurativa del Suo datore di lavoro. In caso di controversia, il professionista/ struttura sanitaria che La segue dovrà attendere la decisione della Workers' Compensation Board prima di richiederLe il pagamento delle spese mediche. Qualora non abbia avviato la pratica o se la Workers' Compensation Board decida che il suo infortunio non dipenda dalla sua attività lavorativa, dovrà farsi carico personalmente delle spese mediche.
8. Lei ha il diritto di essere rappresentato da un avvocato o da un professionista munito di licenza, pur se non obbligatoriamente. Nel caso in cui decida di rivolgersi a un professionista, non è necessario pagare direttamente le sue parcelle. Le tariffe verranno stabilite dalla Workers' Compensation Board e detratte dal Suo premio.
9. Se ha difficoltà a procurarsi il modulo di richiesta di indennizzo o necessita aiuto per compilarlo, se ha altre domande o problemi relativi all'infortunio sul lavoro, La invitiamo a rivolgersi a una agenzia della Workers' Compensation Board.



ROBERT E. BELOTEN, CHAIR/PRESIDENTE

Workers' Compensation benefits, when due, will be paid by: (L'indennità per infortunio sul lavoro, se dovuta, sarà corrisposta da:)

Name, address and telephone number of licensed insurance carrier, authorized grop selfisurer or main office of authorized self-insurer (Nome, indirizzo e numero di telefono

Insurance Carrier Name -
Address - PO Box 881716, San Francisco, CA 94188
Phone - 800-661-6029 Fax - 415-675-5469

For Insurance Carriers ONLY: Policy No.
(SOLO per compagnie assicurative: N. Polizza)

Policy in Force from. ..to
(Polizza in vigore da) *(a)*

Name of employer (Nome del datore di lavoro)

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS. (LA PRESENTE INFORMATIVA DEVE ESSERE ESPOSTA BENE IN VISTA PRESSO LA SEDE DEL DATORE DI LAVORO O PRESSO LA SEDE DELL'AZIENDA.

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.
(Nel caso in cui un datore di lavoro non esponga la presente informativa presso la sua sede o presso la sede dell'azienda, incorre in una multa pari a 250$ per ogni violazione.)

STATE OF NEW YORK - WORKERS" COMPENSATION BOARD
УПРАВЛЕНИЕ ПО КОМПЕНСАЦИЯМ РАБОТНИКАМ, ШТАТ НЬЮ-ЙОРК

NOTICE OF COMPLIANCE
TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
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8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

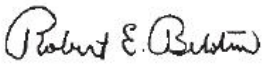
NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5202

Statewide Fax/Единый региональный номер факса:
877-533-0337

ИЗВЕЩЕНИЕ О СОБЛЮДЕНИИ УСТАНОВЛЕННЫХ ТРЕБОВАНИЙ
ИНФОРМАЦИЯ ДЛЯ РАБОТНИКОВ

ВАЖНАЯ ИНФОРМАЦИЯ ДЛЯ РАБОТНИКОВ, ПОЛУЧИВШИХ НА ПРОИЗВОДСТВЕ ТРАВМЫ ИЛИ ПРОФЕССИОНАЛЬНЫЕ ЗАБОЛЕВАНИЯ.

1. Во исполнение Закона о Компенсациях работникам, работодатель разместил данную информацию о правах работников, получивших травмы на производстве.
2. В случае получения производственной травмы необходимо уведомить об этом работодателя в течение 30 дней, в противном случае пострадавшему работнику будет отказано в выплате компенсации.
3. Пострадавший на рабочем месте работник имеет право на любую необходимую медицинскую помощь, и должен без промедления обратиться за ней.
4. Работник, получивший травму или заболевание на рабочем месте, имеет право обратиться к врачу любой специализации по своему усмотрению, в том числе, к ортопеду, мануальному терапевту или психологу, оказывающему медицинские услуги, принимающему с разрешения Управления по компенсациям работникам штата Нью-Йорк пациентов, направленных Управлением. Однако, если работодатель придерживается списка сертифицированных рекомендованных специалистов и лечебных учреждений, то, в первую очередь, пострадавшему на производстве работнику необходимо обратиться к специалисту, выбранному работодателем. При этом работодатель обязан выдать работнику документ, в котором будут изложены права работника на дальнейшее медицинское обслуживание.
5. Работнику, получившему производственную травму или заболевание, следует предупредить своего лечащего врача о необходимости должным образом регистрировать и хранить все медицинские справки и заключения, поскольку они будут необходимы при подаче заявления о выплате компенсации в Управление по компенсациям работникам и выбранную работодателем страховую компанию, информация о которой приведена в нижней части документа.
6. Если в результате полученной на рабочем месте травмы работник потерял трудоспособность на семь дней и более, вынужден был перейти на работу с меньшей заработной платой или если травма привела к стойкому нарушению функций какой-либо части тела, или органа, то работник имеет право на получение компенсации за потерянное время. Если после травмы, полученной на работе, работник не может без внешней помощи вернуться к прежней работе, то работнику также может быть предоставлено медицинское обслуживание для восстановления трудоспособности.
7. Работник, получивший травму/заболевание на рабочем месте, не обязан платить за какое-либо потребовавшееся в этой связи медицинское обслуживание самостоятельно. Медицинское учреждение направляет счет за услуги пострадавшему работнику в страховую компанию, выбранную работодателем. В случае возникновения разногласий по этому вопросу, прежде чем требовать у пострадавшего на рабочем месте пациента оплаты оказанных ему/ей услуг, медицинское учреждение обязано дождаться решения Управления по данному вопросу. Если работник не подал заявление о выплате компенсации в связи с получением травмы на производстве, или Управлением было установлено, что полученная работником травма не была связана с его/ее работой, то работник обязан самостоятельно оплатить услуги медицинского учреждения.
8. Пострадавший на рабочем месте работник имеет право на то, чтобы его интересы представлял адвокат или имеющий лицензию представитель, однако это не обязательно. В случае, если получивший травму на рабочем месте работник нанимает представителя, то он/она не обязан оплачивать услуги представителя самостоятельно. Размер платы за услуги представителя будет назначен Управлением, и вычтен из причитающейся пострадавшему работнику компенсации.
9. По вопросам получения бланков заявлений, помощи в заполнения бланков и иным вопросам и проблемам, связанным с получением травм и заболеваний на рабочем месте, обращайтесь в любое представительство Управления по компенсациям работникам.



ROBERT E. BELOTEN, CHAIR/ПРЕДСЕДАТЕЛЬ

Workers' Compensation benefits, when due, will be paid by: (Причитающиеся работникам компенсационные выплаты будут выплачены:)

Name, address and telephone number of licensed insurance carrier, authorized grop selfisurer or main office of authorized self-insurer (Название, адрес и телефон аккредитованной страховой компании, лица, уполномоченного осуществлять групповое самострахование или его главной конторы)

Insurance Carrier Name -
Address - PO Box 881716, San Francisco, CA 94188
Phone - 800-661-6029 Fax - 415-675-5469

For Insurance Carriers ONLY: Policy No. (№ страхового полиса (указывают ТОЛЬКО страховые компании)).....

Policy in Force from.....*to*.....
(Срок действия полиса с) *(по)*

Name of employer (Имя работодателя)

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

(ДАННОЕ ИЗВЕЩЕНИЕ ДОЛЖНО БЫТЬ РАЗМЕЩЕНО НА ВИДНЫХ МЕСТАХ В РАБОЧИХ ПОМЕЩЕНИЯХ РАБОТОДАТЕЛЯ И ОКОЛО НИХ.)

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

(Отсутствие данного извещения на видных местах в рабочих помещениях работодателя или около них, наказывается штрафом в размере $250 за каждый выявленный факт нарушения.)

STATE OF NEW YORK - WORKERS" COMPENSATION BOARD
STAN NOWY JORK — KOMISJA DS. ODSZKODOWAŃ PRACOWNICZYCH

NOTICE OF COMPLIANCE
TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

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NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5202

Statewide Fax/Nr faksu (stanowy): 877-533-0337

INFORMACJA O ZGODNOŚCI
DLA PRACOWNIKÓW

WAŻNE INFORMACJE DLA PRACOWNIKÓW, KTORY DOZNALI URAZU W PRACY LUB ZACHOROWALI NA CHOROBĘ ZAWODOWĄ W CZASIE PRACY.

1. Umieszczając niniejszą informację oraz informacje na temat praw pracowników, którzy ulegli wypadkowi, pracodawca postępuje zgodnie z przepisami WCL.
2. W przypadku niepowiadomienia pracodawcy w ciągu 30 od daty powstania urazu wniosek o odszkodowanie zostanie odrzucony, należy zatem niezwłocznie zgłaszać fakt doznania urazu.
3. Poszkodowany pracownik ma prawo do uzyskania wszelkiej niezbędnej pomocy medycznej i powinien ją uzyskać w trybie natychmiastowym.
4. Poszkodowany pracownik ma prawo do wyboru lekarza, podiatry, chiropraktyka lub psychologa na podstawie skierowania wydanego przez lekarza, który przyjmuje pacjentów stanu Nowy Jork upoważnionych do odszkodowań pracowniczych i który jest zatwierdzony przez Komisję. Jeżeli jednak pracodawca korzysta z ubezpieczenia typu PPO, należy najpierw być leczonym przez dostawcę usług medycznych wybranego przez pracodawcę. Pracodawca winien przekazać poszkodowanemu pracownikowi pisemne oświadczenie o jego prawach dotyczących dalszego leczenia.
5. Należy poprosić lekarza o przekazanie kopii dokumentacji medycznej dotyczącej wniosku do Komisji ds. Odszkodowań Pracowniczych i ubezpieczyciela pracodawcy, wskazanego w dolnej części niniejszego formularza.
6. Jest Pan/Pani upoważniony(-a) do świadczeń z tytułu utraty czasu, jeżeli odniesiony uraz uniemożliwia podjęcie pracy w ciągu więcej niż siedmiu dni, zmusza do podjęcia pracy gorzej wynagradzanej lub skutkuje trwałą niepełnosprawnością dowolnej części ciała. Może Panu/Pani przysługiwać prawo do korzystania z usług rehabilitacyjnych, jeżeli wymaga Pan/Pani pomocy w powrocie do pracy.
7. Nie należy płacić bezpośrednio żadnym dostawcom usług medycznych. Powinni oni wysłać wystawione rachunki do ubezpieczyciela Pana/Pani pracodawcy. W przypadku wątpliwości dostawca usług medycznych musi poczekać na decyzję Komisję, nim podejmie próbę ściągnięcia należności od Pana/Pani Jeżeli Pan/Pani nie zgłosi roszczenia lub Komisja uzna, że odniesiony uraz nie jest związany z wykonywaną pracą zawodową, może być Pan/Pani obciążona kosztami leczenia.
8. Jest Pan/Pani uprawniona do skorzystania z usług prawnika lub licencjonowanego zastępcy, który będzie Pana/Panią reprezentował w sprawie, nie jest to jednak wymagane. W przypadku wynajęcia zastępcy prawnego nie należy bezpośrednio jemu opłacać wystawionych za te usługi rachunków. Wszelkie opłaty zostaną zatwierdzone przez Komisję zostaną potrącone z kwoty przyznanego świadczenia.
9. W razie trudności w uzyskaniu formularza wniosku lub jeżeli zachodzi potrzeba uzyskania pomocy w jego wypełnieniu, a także w przypadku pytań lub problemów związanych z urazem powstałym podczas wykonywania pracy zawodowej prosimy o kontakt z dowolnym biurem Komisji ds. Odszkodowań Pracowniczych.

Robert E. Beloten

ROBERT E. BELOTEN, CHAIR/PRZEWODNICZĄCY KOMISJI

Workers' Compensation benefits, when due, will be paid by: (Świadczenia w ramach odszkodowań pracowniczych będą wypłacane w odpowiednim terminie przez:)

Name, address and telephone number of licensed insurance carrier, authorized grop selfisurer or main office of authorized self-insurer (Nazwa, adres i nr telefonu licencjonowanego towarzystwa ubezpieczeniowego, autoryzowanego samoubezpieczyciela lub głównego biura autoryzowanego samoubezpieczyciela)

Insurance Carrier Name -
Address - PO Box 881716, San Francisco, CA 94188
Phone - 800-661-6029 Fax - 415-675-5469

For Insurance Carriers ONLY: Policy No. (TYLKO dla ubezpieczycieli: Nr polisy TYLKO dla ubezpieczycieli: Nr polisy) .....

Policy in Force from..... *to* .....
(Polisa obowiązująca od) *(do)*

Name of employer (Nazwa pracodawcy)

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

(NINIEJSZĄ INFORMACJĘ NALEŻY UMIEŚCIĆ W WIDOCZNYM MIEJSCU W LUB W POBLIŻU MIEJSCA LUB MIEJSC PROWADZENIA DZIAŁALNOŚCI PRZEZ PRACODAWCĘ.)

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

(Niezastosowanie się do wymogu umieszczenia niniejszej informacji w oraz w pobliżu miejsca lub miejsc prowadzenia działalności przez pracodawcę może skutkować nałożeniem kary w wysokości 250 $ za każdy przypadek niezastosowania się do wymogu.)

C-105P (10-12) Workers' Compensation Board Prescribed of by Chairman State New York www.wcb.ny.gov

State of New York
WORKERS' COMPENSATION BOARD

PRESCRIBED COPY
Form C-105.1

Notice to be Posted by Employer Under NY WCL Section 51 for Automotive or Horse-Drawn Vehicles

Color: White
Size: 6" X 4"
Stock: Index or Ledger

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

The undersigned employer hereby gives notice that he/she has conformed to the provisions of the Workers' Compensation Law and the rules of the Workers' Compensation Board of the State of New York, and that he/she has secured the payment of compensation to his/her employees, and the dependents of employees, engaged in employments enumerated in or brought within the provisions of said law. Such compensation has been secured for such employees in accordance with Section 50 of the Workers' Compensation Law, by insuring with:

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer:

Insurance Carrier Name -
Address - PO Box 881716, San Francisco, CA 94188
Phone - 800-661-6029 Fax - 415-675-6029

Policy No.....Policy in Force from ..... to .....
(For Insurance Carriers Only)

..... By .....
Legal Name of Insured (Employer) Signature of Employer

Failure by an employer to post this notice in an automotive or horse-drawn vehicle as required by NY WCL Section 51, or in every vehicle used to move household goods or services, may result in a $250 penalty for each violation.

C-105.1 (9-05)

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

Section 51 of the NYS Workers' Compensation Law

Every employer who has complied with section fifty of this article shall post and maintain in a conspicuous place or places in and about his place or places of business typewritten or printed notices in form prescribed by the chairman, stating the fact that he has complied with all the rules and regulations of the chairman and the board and that he has secured the payment of compensation to his employees and their dependents in accordance with the provisions of this chapter, but failure to post such notice as herein provided shall not in any way affect the exclusiveness of the remedy provided for by section eleven of this chapter. Every employer who owns or operates automotive or horse-drawn vehicles and has no minimum staff of regular employees required to report for work at an established place of business maintained by such employer and every employer who is engaged in the business of moving household goods or furniture shall post such notices in each and every vehicle owned or operated by him. Failure to post or maintain such notice in any of said vehicles shall constitute presumptive evidence that such employer has failed to secure the payment of compensation. The chairman may require any employer to furnish a written statement at any time showing the stock corporation, mutual corporation or reciprocal insurer in which such employer is insured or the manner in which such employer has complied with any provision of this chapter. Failure for a period of ten days to furnish such written statement shall constitute presumptive evidence that such employer has neglected or failed in respect of any of the matters so required. Any employer who fails to comply with the provisions of this section shall be required to pay to the board a fine of up to two hundred fifty dollars for each violation, in addition to any other penalties imposed by law to be deposited into the uninsured employers' fund.

C-105.1 Reverse (9-05)

WORKERS' COMPENSATION BOARD
New York State

State of New York - Workers' Compensation Board

Employer's First Report of Work-Related Injury/Illness

C-2F

A work-related injury or illness must be reported within 10 days (Per Section 110) of the injury/illness or be subject to a penalty. Employers are not required to submit form C-2F to the Workers' Compensation Board if the employer's insurer will be submitting the accident information electronically to the Board on the employer's behalf. If you need assistance completing this form, please contact your insurer for guidance on the best method of reporting work-related accident information. If you submit this form to the Board, please send it to P.O. Box 5205, Binghamton, NY 13902 and provide a copy to your insurer.

Employee Name _____

WCB Case Number (JCN) _____ **Date of Injury** _____

Claim Administrator Claim Number _____

INSURER / CLAIM ADMINISTRATOR INFORMATION

Insurer Name _____ **Insurer ID** _____

Name _____

Info/Attn _____

Address _____

City _____ **State** _____

Postal Code _____ **Country** _____

Claim Admin ID _____

EMPLOYEE INFORMATION

First Name _____ **Middle Name/Initial** _____

Last Name _____ **Suffix** _____

Mailing Address _____

City _____ **State** _____

Postal Code _____ **Country** _____

Phone Number _____ **Date of Hire** _____

Date of Birth _____ **Gender** ☐ Male ☐ Female ☐ Unknown

Employee SSN _____

Occupation Description _____

CLAIM INFORMATION

Time of Injury _____ **Date Employer Had Knowledge of the Injury** _____

Employment Status _____ **Date Employer Had Knowledge of Date of Disability** _____

Estimated Weekly Wage _____ **Number of Days Worked Per Week** _____

Work Week Type ☐ Standard Work Week ☐ Fixed Work Week ☐ Varied Work Week

Work Days Scheduled ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

EMPLOYEE INJURY

Full Wages Paid for Date of Injury ☐ Yes ☐ No **Employer Paid Salary in Lieu of Compensation** ☐ Yes ☐ No

Initial Treatment ☐ No Medical Treatment ☐ Minor On-Site Treatment By Employer ☐ Minor Clinic/Hospital Treatment
☐ Emergency Evaluation ☐ Hospitalization Greater Than 24 Hours ☐ Future Major Medical/Lost Time Anticipated

Death Result of Injury ☐ Yes ☐ No ☐ Unknown **Date of Death** _____ **Number of Dependents** _____

Nature of Injury (i.e. Laceration, Burns, Fracture, Strain, etc) _____

Part of Body (i.e. left arm, right foot, head, multiple, etc) _____

Cause of Injury (i.e. Motor Vehicle, Machine, Strain or Injury by lifting, etc) _____

Accident/Injury Description (see instructions)

WORK STATUS

Initial Date Last Day Worked _____ **Return To Work Type** ☐ Actual ☐ Released

Initial Date Disability Began _____ **Physical Restrictions** ☐ Yes ☐ No

Initial Return to Work Date _____ **Return To Work Same Employer** ☐ Yes ☐ No

ACCIDENT LOCATION AND WITNESSES

Premises (see instructions) ☐ Employer ☐ Lessee ☐ Other

Organization Name _____

Street _____ **State** _____

City _____ **Postal Code** _____

County _____ **Country** _____

Location Narrative _____

Witnesses **Business Phone Number**

_____ _____

_____ _____

_____ _____

EMPLOYER INFORMATION

Name _____ Employer FEIN _____

UI Number _____ Manual Classification Code _____

Industry Code _____

Info/Attn _____

Mailing Address _____

City _____ State _____

Postal Code _____ Country _____

Physical Addr _____

City _____ State _____

Postal Code _____ Country _____

Contact Name _____

Contact Business Phone Number _____

INSURED INFORMATION

Insured Name _____ Insured FEIN _____

Insured Type ☐ Insured ☐ Self-Insured ☐ Uninsured Insured Location ID _____

Policy Number ID _____

Policy Effective Date _____ Policy Expiration Date _____

An employer or carrier, or any employee, agent, or person acting on behalf of an employer or carrier, 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.

The above information is true to the best of my knowledge and belief.

If prepared by the employer:

Signature of Person Preparing Form _____ Date _____

Print Name _____

Title _____ Phone Number _____

NEW YORK STATE | Workers' Compensation Board

EMPLOYER'S STATEMENT OF WAGE EARNINGS (Preceding the Date of Injury/Illness)

Claim Information - ALL COMMUNICATION SHOULD INCLUDE THESE NUMBERS

Date of Injury/Illness: _____ WCB Case #: _____ Claim Administrator Claim (Carrier Case) #: _____

Injured Worker Information

Last Name: _____ First Name: _____ MI: ___

Mailing Address: _____ Line 2: _____

City: _____ State: _____ Zip Code: _____

Job Title: _____ Social Security #: _____

Insurer Information

Insurer Name: _____ Insurer ID (W#): _____

Mailing Address: _____ Line 2: _____

City: _____ State: _____ Zip Code: _____

Insurer Phone #: _____ Insurer Fax #: _____ Email Address: _____

Employer Information

Employer Name: _____

Mailing Address: _____ Line 2: _____

City: _____ State: _____ Zip Code: _____

Employer Phone #: _____ Federal Tax ID #: _____ The Tax ID # is the (check one): ☐ SSN ☐ EIN

To determine Average Weekly Wage, the Board needs the gross weekly earnings for the 52 weekly periods immediately preceding the date of the injury/illness. This information can be provided by 1) attaching detailed payroll information that indicates days paid and gross weekly earnings; 2) if injured worker is paid by salary and his or her weekly pay does not change from week-to-week, attach document(s) providing their salary information for the previous 52 weeks; or 3) by completing and submitting the **Injured Worker Payroll** section on page 2 of this form.

If the injured worker has not worked at the same employment for one year or a substantial part of the year, also attach detailed payroll information for an employee of the same class, or complete and submit the **Employee of the Same Class Payroll** section on page 2 of this form. "Substantial part of the year" does not require any particular number of days worked but as a guideline 234 days at 5 days per week and 270 days at 6 days per week .

1. Payroll information is: ☐ attached ☐ completed on page 2

2. Did the injured worker's compensation include board, rent, housing, tips and/or gratuities, in addition to gross weekly earnings? ☐ Yes ☐ No

   If Yes, what was the weekly value: _____

   Nature of the compensation:

3. Basis for the injured worker pay rate is: ☐ hourly ☐ daily ☐ weekly ☐ monthly ☐ annually

4. The injured worker works a: ☐ 5 ☐ 6 ☐ 7 ☐ Other day week. If Other, Explain: _____

5. Total days paid in the preceding 52 weeks: ____ 6. Total gross amount paid including overtime in the preceding 52 weeks: _____

7. Was there any wage adjustment made that affected the 52-week period? (If injured worker was in military service, please indicate and provide date of discharge.) ☐ Yes ☐ No

   If "Yes", explain:

8. Was the injured worker laid off during the preceding 52 weeks? ☐ Yes ☐ No

   If Yes, provide dates of layoff : _____

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.

Prepared By - The above information is true and to the best of my knowledge and belief.

Last Name: _____ First Name: _____ MI: ___

Employer Name: _____

Official Title: _____ Daytime Phone #: _____

Email Address: _____ Date of this Report: _____

Injured Worker's Name: _____ Date of Injury/Illness: _____ WCB Case #: _____

INJURED WORKER PAYROLL Enter the injured worker's gross weekly earnings for the 52 weekly periods immediately preceding the date of injury/illness. In the "**Days Paid**" column enter the number of days compensated, including paid time off.

Week No.	Week Ending Date	Days Paid	Gross amount paid including overtime	Week No.	Week Ending Date	Days Paid	Gross amount paid including overtime	Week No.	Week Ending Date	Days Paid	Gross amount paid including overtime
1				19				37			
2				20				38			
3				21				39			
4				22				40			
5				23				41			
6				24				42			
7				25				43			
8				26				44			
9				27				45			
10				28				46			
11				29				47			
12				30				48			
13				31				49			
14				32				50			
15				33				51			
16				34				52			
17				35				Total:			
18				36							

EMPLOYEE OF THE SAME CLASS PAYROLL. If the injured worker has not worked at the same employment for one year or a substantial part of the year, enter the gross weekly earnings for an employee of the same class. "Substantial part of the year" does not require any particular number of days worked, but as a guideline 234 days at 5 days per week and 270 days at 6 days per week.

Employee of the Same Class

First Name: _____ Last Name: _____ MI: ___

Job Title: _____

Week No.	Week Ending Date	Days Paid	Gross Amount Paid including Overtime	Week No.	Week Ending Date	Days Paid	Gross Amount Paid including Overtime	Week No.	Week Ending Date	Days Paid	Gross Amount Paid including Overtime
1				19				37			
2				20				38			
3				21				39			
4				22				40			
5				23				41			
6				24				42			
7				25				43			
8				26				44			
9				27				45			
10				28				46			
11				29				47			
12				30				48			
13				31				49			
14				32				50			
15				33				51			
16				34				52			
17				35				Total:			
18				36							

Instructions for Completing Employer's Statement of Wage Earnings (Form C-240)

CLAIM INFORMATION

Date of Injury/Illness: Enter the date the injured worker was injured or noticed they were ill. Enter the date in month/day/year format. Include the four digit year.
WCB Case #: The Workers' Compensation Board Case number.
Insurer Case #: The Claim Administrator Claim (Carrier Case) number.

INJURED WORKER INFORMATION

Last Name, First Name, MI: Enter the injured worker's full legal name.
Mailing Address: Enter the injured worker's full address, including PO Box, if applicable, city or town, state, zip code.
Social Security #: Enter the injured worker's Social Security Number.

INSURER INFORMATION

Insurer Name: Enter the name of the Workers' Compensation Insurer or Self-Insured Group name.
Mailing Address: Enter the insurer or claims administrator address, including PO Box, if applicable, city or town, state, zip code.
Phone #: Enter the insurer phone number, including area code and extension, if applicable.
Fax #: Enter the insurer fax number, including area code, if applicable.
Email Address: Enter the insurer or claims administrator email address.

EMPLOYER INFORMATION

Employer Name: Enter the name of the injured worker's employer.
Mailing Address: Enter the employer's full address, including PO Box, if applicable, city or town, state, zip code.
Phone #: Enter the employer phone number, including area code and extension, if applicable.
Federal Tax ID #: Enter the employer Federal Tax ID number.

1. **Payroll Information** - Indicate if payroll information is attached to this form or if the information is entered on page 2.
2. **Other Earnings**: If the injured worker received board, rent, housing, tips and/or other gratuities, provide the weekly value and describe the additional earnings. Note: Other earnings does not include accrued time such as vacation.
3. **Wage Information**: Enter the basis for injured worker's pay rate (hourly, daily, weekly, monthly or annually).
4. **Days Worked Per Week:** Check the number of days per week the injured worker's work schedule is based on. If it is other than a 5, 6 or 7 day week, explain.
5. **Total Days Paid**: Enter the total number of days for which the injured worker was paid in the 52 weeks immediately prior to the date of injury/ illness, including paid time off. If days paid (compensated) is zero, provide an explanation in question 7. Do not include accrued time such as vacation time.
6. **Total Gross Amount Paid Including Overtime:** Enter the injured worker's total gross pay (prior to taxes) for the 52 weeks immediately prior to the date of injury/illness, including overtime. Do not use the injured worker's take-home pay. "Wages" means the money rate at which the service rendered by the injured worker is compensated under the contract of hire in force at the time of the injury.
7. **Wage Adjustments**: If any wage adjustments (e.g., if the injured worker was demoted) were made during the 52 weeks prior to the injury/ illness, explain. Advise if the injured worker was in military service during the 52 week period, and give date of discharge.
8. **Laid Off**: Indicate if the injured worker was laid off during the 52 week period immediately prior to the date of injury/illness, and provide the dates of layoff.

PREPARED BY

Last Name, First Name, MI: Enter the preparer's full legal name.
Employer Name: Enter the name of the preparer's employer.
Official Title: Enter the preparer's official title.
Phone #: Enter the preparer's phone number, including area code and extension, if applicable.
Email Address: Enter the preparer's email address.
Date of this Report: Enter the date this report was prepared.

INSTRUCTIONS FOR COMPLETING INJURED WORKER PAYROLL AND EMPLOYEE OF SAME CLASS PAYROLL

Injured Worker Payroll

Week Ending Date: Enter the week ending dates for each of the 52 weeks immediately prior to the date of injury/illness.
Days Compensated (including paid time off): In the **"Days Paid"** column, give the number of days worked in the employment for which the worker was paid, including paid time off. If days paid (compensated) is zero, provide an explanation in question 7 on page 1. Do not include accrued time such as vacation time.
Gross Amount Paid Including Overtime: Enter the injured worker's average weekly gross pay (prior to taxes), including overtime. Do not use the injured worker's take-home pay. "Wages" means the money rate at which the service rendered by the injured worker is compensated under the contract of hire in force at the time of the injury.

Employee of the Same Class Payroll: Give the gross weekly wages for an employee of the same class if the injured worker worked less than a substantial part of the year (234 days for a 5-day worker, or 270 days for a 6-day worker). In addition, provide name of employee in the same class and their job title. NOTE: "Number of days worked" is a guideline, and the Board may find that an injured worker has worked a substantial part of the year even if the injured worker did not work 234 days (5-day worker) or 270 days (6-day worker).

If attaching payroll information, do not submit page 2. All attachments should include the Injured Worker's full name, WCB Case # and Date of Injury/Illness.

Submit by mail or electronically directly to:

New York State Workers' Compensation Board
PO Box 5205
Binghamton, NY 13902-5205

Fax #: (877) 533-0337
WCB Address for Email Filing: wcbclaimsfiling@wcb.ny.gov
WCB Web Upload Link: https://wcbdoc.services.conduent.com/

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
100 BROADWAY-MENANDS
ALBANY, NY 12241
(877) 632-4996

You were injured at work. What now?

The New York State Workers' Compensation Board has received notice you suffered a workplace injury or illness, so we're preparing a workers' compensation case in your name. You may have already received medical treatment. If you haven't, you should seek medical care as soon as possible.

A Worker's Responsibilities

- You must tell your employer, in writing, when, where and how you were injured. Do this within 30 days of injury.
- *Medical reports are necessary for your case.* Advise your doctors that you have a work-related injury, and give the name of your employer. Do not pay for your care yourself or use other health insurance. Tell your doctor to file reports with the Board and with your employer or its insurance carrier. If your case is disputed, the Board needs a medical report on your injury to begin resolving your claim.

Starting a Case

Once your employer knows of your injury, it must notify this Board. *You should file an employee claim (C-3 form) reporting your injury as soon as possible.* (You **must** notify the Board of your injury or illness within two years.) If you injured the same body part before, or had a similar illness, you must also file a Form C-3.3.

If you haven't already filed a C-3 or C-3.3 (if necessary), there are three ways to do it.

- Visit *www.wcb.ny.gov/content/main/onthejob/howto.jsp* to complete the form.
- Complete the enclosed paper forms, and mail them to the Board.
- Call 1-866-396-8314. A Board employee will complete the form with you.

Health Care Bills

Do not pay your doctor or hospital. Those bills are paid by the insurer unless the Board disallows your case. If your case is disputed, the providers are paid when the Board decides your case. If the Board decides against you, or if *you don't pursue a case, you will have to pay the doctor or hospital.*

Your employer's insurance covers medically necessary drugs and equipment your doctor prescribes. You're also entitled to carfare or necessary expenses incurred when traveling for treatment. (Get receipts for those expenses.)

Generally, you can choose any doctor authorized by the Board. You can also use occupational health clinics. However, if your employer's insurer has a preferred provider organization to provide care for workers' compensation injuries, you must get your initial treatment from those providers. If that insurer also has a pharmacy or diagnostic network, you must get service within these networks. If the carrier uses these networks, it must also tell you its service providers and how to use them.

Benefits for Lost Wages

You are entitled to a portion of your lost wages if your injury affects you in one or more ways:

1. It keeps you from work for more than seven days;
2. Part of your body is permanently disabled;
3. Your pay is reduced because you now work fewer hours or do other work.

An employer or insurer can accept your claim and begin paying your lost wage benefit promptly. Sometimes, employers and carriers dispute a claim. When that occurs, the Board strives to resolve most cases within 90 days.

You may hire an attorney or licensed representative, who can be helpful with complex or disputed claims, but it isn't required. The Board sets their fees and they will be deducted from your lost wages award. You or your family should not pay anything directly to your attorney or licensed representative.

If your case is disputed, you may receive disability benefits while the case is heard. You'd pay them back out of your lost wages award. To get a DB-450 form, visit *www.wcb.ny.gov/content/main/forms/db450.pdf* or a Board office, or call (800) 353-3092.

Help is Available

People sometimes need help getting back to work. Your employer may have a *return to work* program that can get you back to work in light duty or an alternative position while you heal. An injury can also cause family or financial problems. The Workers' Compensation Board has rehabilitation counselors and social workers to help. Call (877) 632-4996 for more assistance.

What's Next?

Your employer or its insurance carrier will contact you if your claim is accepted. When that happens, your treatment will be paid and lost wage benefits begin. If your case is challenged, the Board will notify you about resolving the case. If more information is necessary, the Board will contact you and tell you how to file it.

Important Contact Information

Workers' Compensation Board	(877)632-4996	General_Information@wcb.ny.gov
Disability Benefits	(800)353-3092	www.WCB.NY.Gov
NYS Bar Association Lawyer Referral and Information Service	(800)342-3661	lr@nysba.org.

WORKERS' COMPENSATION BOARD
New York State

Employee Claim

State of New York - Workers' Compensation Board

C-3

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.ny.gov.

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Employee)

1. Name: _____ (First / MI / Last) 2. Date of Birth: _____/_____/_____

3. Mailing address: _____ (Number and Street/PO Box / City / State / Zip Code)

4. Social Security Number: ___-___-_____ 5. Phone Number: (____)_____ 6. Gender: ☐ Male ☐ Female

7. Will you need a translator if you have to attend a Board hearing? ☐ Yes ☐ No If yes, for what language? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (____)_____

3. Your work address: _____ (Number and Street / City / State / Zip Code)

4. Date you were hired: _____/_____/_____ 5. Your supervisor's name: _____

6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

_____

_____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____

2. What types of activities did you normally perform at work? _____

_____

3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: _____

4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____

6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: _____

_____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: _____/_____/_____ 2. Time of injury: _____ ☐ AM ☐ PM

3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

_____

4. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? _____

_____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

_____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

_____

_____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

_____

_____

YOUR NAME: _____ DATE OF INJURY/ILLNESS: _____/_____/_____
First MI Last

D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what? _____

9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No
If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): _____
If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____

10. Have you given your employer (or supervisor) notice of injury/illness? ☐ Yes ☐ No
If yes, notice was given to: _____ ☐ orally ☐ in writing Date notice given: _____/_____/_____

11. Did anyone see your injury happen? ☐ Yes ☐ No ☐ Unknown If yes, list names: _____

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☐ Yes, on what date? _____/_____/_____ ☐ No, skip to Section F.
2. Have you returned to work? ☐ Yes ☐ No If yes, on what date? _____/_____/_____ ☐ regular duty ☐ limited duty
3. If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed
4. What is your gross pay (before taxes) per pay period? _____ How often are you paid? _____

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? _____/_____/_____ ☐ None received (skip to question F-5)
2. Were you treated on site? ☐ Yes ☐ No
3. Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☐ Emergency Room ☐ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours
Name and address where you were first treated: _____
_____ Phone Number: (_____)_____
4. Are you still being treated for this injury/illness? ☐ Yes ☐ No
Give the name and address of the doctor(s) treating you for this injury/illness: _____
_____ Phone Number: (_____)_____
5. Do you remember having another injury to the same body part or a similar illness? ☐ Yes ☐ No
If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**
_____
_____
_____
6. Was the previous injury/illness work related? ☐ Yes ☐ No
If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Employee's Signature: _____ Print Name: _____ Date: _____/_____/_____

On behalf of Employee: _____ Print Name: _____ Date: _____/_____/_____

An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): _____ Date: _____/_____/_____

Print Name: _____ Title: _____

ID No., if any: **R** _____ If Licensed Representative, License No.: _____ Expiration Date: _____/_____/_____

Limited Release of Health Information (HIPAA)

C-3.3

State of New York - Workers' Compensation Board

WCB Case No. *(if you know it):*_____

To Claimant: If you received treatment for a *previous* injury to the same body part or for an illness similar to the one described in your current Claim, fill out this form. This form allows the health care providers you list below to release health care information about your previous injury/illness to your employer's workers' compensation insurer. The federal HIPAA law (Health Insurance Portability and Accountability Act of 1996) says you have a right to get a copy of this form. If you do not understand this form, talk to your legal representative. If you do not have a legal representative, the Advocate for Injured Workers at the Workers' Compensation Board can help you. Call: 800-580-6665.

To Health Care Provider: A **copy** of this HIPAA-compliant release allows you to disclose health information. If you send records to the employer's workers' compensation insurer in response to this release, also mail copies to the Claimant's legal representative. (If no legal representative is listed below, send copies to the Claimant.) Health care providers who release records must follow New York state law and HIPAA.

This release is:

- **Voluntary.** Your health care provider(s) must give you the same care, payment terms, and benefits, whether you sign this form or not.
- **Limited.** It gives your health care provider(s) permission to release only those health records that are related to the previous illness/condition you describe below.
- **Temporary.** It ends when your current claim for compensation is established or disallowed and all appeals are exhausted.
- **Revocable.** You can cancel this release at any time. To cancel, send a letter to the health care provider(s) listed on this form. Also, send a copy of your letter to your employer's workers' compensation insurer and the Workers' Compensation Board. *Note: You may not cancel this release with respect to medical records already provided.*
- **For records only.** It gives your health care provider(s) listed on this form permission to send copies of your health care records to your employer's workers' compensation insurer.

This form does NOT allow your health care provider(s) to release the following types of information:

- **HIV-related information**
- **Psychotherapy notes**
- **Alcohol/Drug treatment**
- **Mental Health treatment** (unless you check below)
- **Verbal information** (your health care providers may not discuss your health care information with anyone)

Any medical records released will become part of your workers' compensation file and are confidential under the Workers' Compensation Law.

A. YOUR INFORMATION (Claimant)

1. Name:_____ 2. Social Security Number:_____-_____-_____
3. Mailing Address: _____
4. Date of Birth: _____/_____/_____ 5. Date of the current injury/illness: _____/_____/_____
6. Current injury/illness, including all body parts injured:_____

_____

7. Your legal representative's name and address (if any):_____

_____

☐ *Check here if you allow your health care provider(s) to release **mental health care** information.*

B. YOUR HEALTH CARE PROVIDER(S)

(List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers attach their contact information to this form.)

1. Provider:_____ 2. Phone Number: (_____)_____
3. Mailing Address: _____
4. Other provider (if any):_____ 5. Phone Number: (_____)_____
6. Mailing Address:_____

C. READ AND SIGN BELOW.

I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above.

_____

Claimant's signature (ink only -- use blue ballpoint pen, if possible.) Date

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below:

_____

Your name Relationship to Claimant Signature (ink only -- use blue ballpoint pen, if possible.) Date

Versión en español al reverso de la forma.

WORKERS' COMPENSATION BOARD
New York State

Divulgación limitada de información sobre la salud
(HIPAA)

C-3.3

Estado de NuevaYork - Junta de Compensación Obrera (WCB)

WCB Case No. (if you know it) (Número de caso WCB *[si lo sabe]*)

Al reclamante: Si usted recibió tratamiento por una lesión anterior en la misma parte del cuerpo o por una enfermedad similar a la que motiva ahora su reclamación, complete este formulario. Este formulario les permite a los proveedores de salud que usted señala a continuación divulgar a la compañía de seguros de compensación obrera de su empleador la información sobre su salud relacionada con su lesión/enfermedad anterior. La Ley federal HIPAA (Ley de portabilidad y responsabilidad del seguro de salud de 1996) establece que usted tiene derecho a recibir una copia de este formulario. Si no comprende este formulario, hable con su representante legal. Si no tiene un representante legal, el Representante de los obreros lesionados de la Junta de Compensación Obrera puede ayudarlo. Llame al 800-580-6665.

Al proveedor de salud: Una **copia** de esta divulgación, redactada según lo que establece la ley HIPAA, le permite divulgar información sobre la salud. Si envía los registros al asegurador de compensación obrera del empleador en respuesta a la presente divulgación, también debe enviar por correo copias al representante legal del reclamante. (Si a continuación no se especifica un representante legal, envíe las copias al reclamante). Los proveedores de salud que divulgan los registros deben cumplir con las leyes del estado de Nueva York y la HIPAA.

Esta divulgación es:

- **Voluntaria.** Su(s) proveedor(es) de salud deben otorgarle la misma atención, condiciones de pago y beneficios, independientemente de que usted firme este formulario o no.
- **Limitada.** Le otorga a su(s) proveedor(es) de salud permiso para divulgar únicamente los registros médicos que se relacionen con la enfermedad/afección anterior que usted describe a continuación.
- **Temporal.** Termina cuando se otorgue o desestime su actual reclamación de compensación y se hayan agotado todas las apelaciones.
- **Revocable.** Usted puede cancelar esta divulgación en cualquier momento. Para hacerlo, envíe una carta al (a los) proveedor(es) de salud que se indican en este formulario. Además, envíe una copia de su carta a la compañía de seguros de compensación obrera de su empleador y a la Junta de Compensación Obrera. *Nota: No podrá cancelar esta divulgación en lo que se refiere a registros médicos que ya se hayan provisto.*
- **Solamente para registros.** Le otorga a su(s) proveedor(es) de salud que se indica(n) en este formulario permiso para enviar copias de sus registros de salud a la compañía de seguros de compensación obrera de su empleador.

Este formulario NO autoriza a su(s) proveedor(es) de salud a divulgar los siguientes tipos de información:

- **Información relacionada con el VIH**
- **Notas de terapia psicológica**
- **Tratamientos por abuso de alcohol o drogas**
- **Tratamiento de salud mental** (a menos que usted lo indique a continuación)
- **Información verbal** (sus doctores no pueden hablar con nadie sobre su información de salud)

Los registros médicos divulgados se incorporarán a su expediente de compensación obrera y son confidenciales conforme a la Ley de compensación obrera.

CONTESTA LAS SIGUIENTES PREGUNTAS, EN INGLÉS SI ES POSIBLE, EN LOS ESPACIOS PROVISTOS Y FIRMA AL FRENTE DE LA FORMA.

A. YOUR INFORMATION (Claimant) INFORMACIÓN PERSONAL (Reclamante)

1. Name (Nombre)
2. Social Security Number (Número de seguro social)
3. Mailing Address (Dirección postal)
4. Date of Birth (Fecha de nacimiento)
5. Date of the current injury/illness (Fecha de la lesión/enfermedad actual)
6. Current injury/illness, including all body parts injured (Descripción de la lesión/enfermedad actual, incluyendo todas las partes del cuerpo lesionadas)
7. Your legal representative's name and address (if any) (Nombre y dirección de su representante legal [si corresponde])

Check here if you allow your health provider(s) to release ***mental health care*** *information. (Marque aquí si autoriza a su(s) proveedor(es) de salud a divulgar información sobre* ***tratamientos de salud mental****.)*

B. YOUR HEALTH CARE PROVIDERS (List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers, attach their contact information to this form.

SU(S) PROVEEDOR(ES) DE SALUD (Enumere todos los proveedores de salud que le han tratado por lesiones previas a las mismas areas del cuerpo ó por enfermedades semejantes.Si son más de 2 proveedores, adjunte su información de contacto a este formulario.)

1. Provider (Proveedor de salud)
2. Phone Number (Nº de teléfono)
3. Mailing Address (Dirección postal)
4. Other provider (if any) (Otro proveedor [si corresponde])
5. Phone Number (Nº de teléfono)
6. Mailing Adress (Dirección postal)

C. READ AND SIGN BELOW

I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above. **LEA Y FIRME A CONTINUACIÓN.** Por la presente solicito que los proveedores de salud aquí enumerados le provean al asegurador de compensación obrera de mi patrono copias de todos los records médicos relacionados a cualquier lesión/enfermedad aquí enumeradas.

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below: (**Si el reclamante no puede firmar**, la persona que firme el formulario en su nombre y representación debe llenar y firmar a continuación)

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Claimant's signature (Firma del reclamante) use solo tinta - preferiblemente azul | Date (Fecha)

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Your name (Su nombre) | Relationship to Claimant (Relación con el reclamante) | Signature(Firma) | Date(Fecha)

Instructions for Completing Form C-3, "Employee Claim"

Please complete this form and send it to the Workers' Compensation Board centralized mailing address listed at the bottom of these instructions. If you need additional help in completing this form, contact the Workers' Compensation Board at **1-877-632-4996. You may also fill this form out online at: http://www.wcb.ny.gov/**

If you do not have or know your Workers' Compensation Board Case Number, please leave this field blank. It is not required to process your claim. Remember to enter your name and the date of your injury/illness on the top of page two.

Section A - Your Information (Employee):

Item 1: Enter your full name, including first name, middle initial, and last name.
Item 2: Enter your date of birth in month/day/year format. Include the four digit year.
Item 3: Enter your mailing address, including P.O. Box, if applicable, city or town, state, and Zip code.
Item 4: Enter your Social Security Number. This is very important to help service your claim faster.
Item 5: Indicate the primary contact phone number, including area code. This may include a cell phone number.
Item 6: Indicate your gender (Male or Female).
Item 7: Board hearings are conducted in English. If you will need a translator to understand the proceeding, the Board will provide one. Check Yes and indicate the language needed.

Section B - Your Employer(s):

Item 1: Indicate the employer you were working for at the time you were injured or became ill.
Item 2: Enter the phone number for this employer, either a primary contact number or the number for your supervisor.
Item 3: Enter the employer's address, including P.O. Box, if applicable, city or town, state, and Zip code.
Item 4: Indicate the date you were hired by this employer.
Item 5: Enter your direct supervisor's name, whom you report to on a regular basis.
Item 6: If you have more than one job, please indicate the names and addresses of all other employers you work for besides the one you were injured at. Please attach a separate sheet if you need more room.
Item 7: Check Yes if you lost time from any of your other jobs as a result of your injury or illness; otherwise, check No.

Section C - Your Job on the Date of the Injury or Illness:

Item 1: Indicate your current job title or job description (e.g., warehouse worker).
Item 2: Indicate your typical work activities for this job (e.g., keeping inventory, unloading trucks, etc.).
Item 3: Check the type of job you had.
Item 4: Enter your gross pay (before taxes) per pay period.
Item 5: Indicate how often you received a paycheck (weekly, bi-weekly, etc.).
Item 6: Indicate if you received any tips or lodging in addition to your regular pay. If you did, describe them.

Section D - Your Injury or Illness:

Item 1: Enter the date when you were injured or the first date you noticed you became ill. Enter the date in month/day/year format. Include the four digit year. If this is an illness or occupational disease, then skip item 2.
Item 2: Enter the time when the injury occurred. Check whether it was AM or PM.
Item 3: Indicate the location where the injury/illness occurred, including the address of the building and the physical location in the building where the injury/illness happened.
Item 4: Check whether this was your normal work location. If it was not, explain why you were at this location.
Item 5: Describe in detail what you were doing at the time of the injury/illness (e.g., unloading boxes from a truck by hand). This explains the events leading up to the injury.
Item 6: Describe in detail how the injury/illness occurred (e.g., I was lifting a heavy box off a truck). This should include all people and events involved in the injury/illness.
Item 7: Indicate fully the nature and extent of your injury/illness, including all body parts injured. Be as specific as possible. (e.g., I strained my back trying to lift a heavy box. It hurts to bend over or hold even lighter objects now.)
Item 8: Indicate if some object was involved in the accident OTHER THAN a licensed motor vehicle. Other objects may include a tool (e.g., hammer), a chemical (e.g., acid), machinery (e.g., forklift or drill press), etc.
Item 9: Indicate if a licensed motor vehicle was involved in the accident. If so, check if the motor vehicle involved was yours, your employer's, or a third party's. Include the license plate number (if known). If your vehicle was involved, fill out the name and address of your automobile liability insurance carrier.
Item 10: Check if you gave your employer or supervisor notice of your injury or illness. If so, indicate who you gave notice to as well as if it was orally or in writing. Include the date you gave notice.
Item 11: Check if anyone else saw the injury happen. If anyone did see it, include their name(s).

Section E - Return to Work:

Item 1: If you stopped working as a result of your work-related injury/illness, check Yes and indicate on what date you stopped working. If you have not stopped working, check No and skip to the next section.

Section E - Return to Work (cont):

Item 2: If you have since returned to work, check Yes. Also indicate on what date you started working again, as well as if you have returned to your Normal Duties or if you are on Limited or Restricted Duty. (If you have not returned to your full pre-injury or illness work duties, then you are on Limited Duty.)

Item 3: If you have returned to work, indicate who you are working for now.

Item 4: Enter your gross pay (before tax pay) per pay period for the job you are working at now. Indicate how often you are receiving a paycheck (weekly, bi-weekly, etc.).

Section F - Medical Treatment for This Injury or Illness:

Item 1: If you did not receive medical treatment for this injury/illness, check None Received and skip to item 5. Otherwise, enter the date you first received treatment for this injury/illness and complete the rest of this section.

Item 2: Check if you were first treated on the job for this injury or illness.

Item 3: Check the location where you first received off site medical treatment for your injury or illness. Include the name and address of the facility as well as the phone number (including area code).

Item 4: If you are still receiving ongoing treatment for the same injury or illness, check Yes and indicate the name and address of the doctor(s) providing treatment as well as the phone number (including area code); otherwise check No.

Item 5: If you believe you already had an injury to the same body part or a similar illness, check Yes and indicate if you were treated by a doctor for this injury or illness. If you were treated by a doctor, indicate the name(s) and address(es) of the doctor(s) whom provided care and **complete and file Form C-3.3 together with this form.**

Item 6: If you had a previous injury or illness, check if your previous injury or illness was work-related. If Yes, check if the injury or illness happened while working for your current employer.

Sign Form C-3 in the place provided for "Employee's Signature on page 2, print your name, and enter the date you signed the form. If a third-party is signing on behalf of the employee, that person should sign on the second signature line. If you have legal representation, your representative **must** complete and sign the attorney/representative's certification section on the bottom of page 2.

What Every Worker Should Do in Case of On-The-Job Injury or Occupational Disease:

1. Immediately tell your employer or supervisor when, where and how you were injured.
2. Secure medical care immediately.
3. Tell your doctor to file medical reports with the Board and with your employer or its insurance carrier.
4. Make out this claim for compensation and send it to the Workers' Compensation Board centralized mailing address. Failure to file within two years after the date of injury may result in your claim being denied. If you need help in completing this form, contact the Workers' Compensation Board at 1-877-632-4996.
5. Go to all hearings when notified to appear.
6. Go back to work as soon as you are able; compensation is never as high as your wage.

Your Rights:

1. Generally, you are entitled to be treated by a doctor of your choice, provided he/she is authorized by the Board. If your employer is involved in a preferred provider organization (PPO) arrangement, you must obtain initial treatment from the preferred provider organization which has been designated to provide health care services for workers' compensation injuries.
2. DO NOT pay your doctor or hospital. Their bills will be paid by the insurance carrier if your case is not disputed. If your case is disputed,
   the doctor or hospital must wait for payment until the Board decides your case. In the event you fail to prosecute your case or the Board decides against you, you will have to pay the doctor or hospital.
3. You are also entitled to be reimbursed for drugs, crutches, or any apparatus properly prescribed by your doctor and for carfares or other necessary expenses going to and from your doctor's office or the hospital. (Get receipts for such expenses.)
4. You are entitled to compensation if your injury keeps you from work for more than seven days, compels you to work at lower wages, or results in permanent disability to any part of your body.
5. Compensation is payable directly and without waiting for an award, except when the claim is disputed.
6. Injured workers or dependents of deceased workers may represent themselves in matters before the Board or may retain an attorney or licensed representative to represent them. If an attorney or licensed representative is retained, his/her fee for legal services will be reviewed by the Board and if approved will be paid by the employer or insurance company out of any compensation benefits due. Injured workers or dependents of deceased workers should not directly pay anything to the attorney or licensed representative representing them in a compensation case.
7. If you need help returning to work, or with family or financial problems because of your injury, contact the Workers' Compensation Board office nearest you and ask for a rehabilitation counselor or social worker.

This form should be filed by sending directly to the address listed below:

New York State Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Toll-Free Number: 877-632-4996

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

STATEMENT OF RIGHTS

TO ALL WORKERS WHO ARE INJURED WHILE WORKING OR WHO SUFFER FROM AN OCCUPATIONAL DISEASE

YOU MAY BE ENTITLED TO WORKERS' COMPENSATION BENEFITS

1. You should file a claim for benefits within two years of the date you are injured, unless your injury is very minor, requiring no medical treatment and causing no lost time from work. If you do not file within two years your right to benefits may be lost. Obtain and file a claim form (Form C-3, or VF-3 for volunteer firefighters, or VAW-3 for volunteer ambulance workers) with the nearest Workers' Compensation Board office (see addresses below).
2. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work. (In volunteer firefighters' and volunteer ambulance workers' cases, compensation for lost time or loss of earning capacity may be payable from date of injury.)
3. You are entitled to obtain any necessary medical treatment related to your injury and you should do so immediately.
4. For the treatment of your work-related injury or illness, you may choose any physician, podiatrist, chiropractor, or psychologist (upon referral from an authorized physician) who is Board authorized and who is accepting workers' compensation patients. If, however, your employer is involved in a certified preferred provider organization (PPO) arrangement, you must obtain initial treatment for any workers' compensation injury or illness from the preferred provider organization. Employers participating in this statutory program are required to provide their employees with written notification describing their employees' rights and obligations under the program.
5. You should inform your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and your employer's insurance company, which is indicated at the bottom of this form.
6. You should not pay any medical providers directly for treatment of your work-related injury or illness. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
7. The employer is liable for the replacement or repair of an employee's prosthesis (e.g., artificial members, false teeth, eyeglasses), which has been lost or damaged in the course of employment, whether or not there was bodily injury to the employee. You are also entitled to be reimbursed for drugs, crutches or any apparatus properly prescribed by your doctor, and transportation and other necessary expenses going to and from your doctor's office or hospital. (You should get receipts for all such expenses.)
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire an attorney or licensed representative, you should not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. Lost time and medical benefits are payable directly without a formal direction from the Board, unless your claim is disputed. If your claim is disputed on the grounds that your injury is not work-related or did not arise in the line of volunteer firefighter or ambulance worker duties, then you may qualify for disability benefits for non-work injuries. For more information on entitlement to disability benefits, contact the Workers' Compensation Board office nearest you.
10. You should go back to work as soon as you are able; compensation is never as high as your wage. If you need help returning to work, or with family or financial problems because of your injury, you should contact the nearest Board office and ask for a rehabilitation counselor or social worker.
11. Your employer may not ask you to waive your right to compensation nor may your employer deduct any money from your pay to contribute to the payment of workers' compensation insurance premiums. Further, you cannot be discharged or discriminated against because you filed a claim for workers' compensation benefits.

IF YOU HAVE DIFFICULTY IN OBTAINING A CLAIM FORM OR NEED HELP IN FILLING IT OUT, OR IF YOU HAVE ANY OTHER QUESTIONS OR PROBLEMS ABOUT A JOB-RELATED INJURY OR DISEASE, CONTACT ANY OFFICE OF THE WORKERS' COMPENSATION BOARD.

This information is a simplified presentation of your rights under the Workers' Compensation Law. It is provided, as required by Section 110 of the Workers' Compensation Law, by your employer's insurance carrier:

Insurance Carrier Name -

Address - PO BOX 881716, San Francisco, CA 94188

Phone- (800) 661-6029 Fax - (415) 675-546

CHAIR
WORKERS' COMPENSATION BOARD

NYS Workers' Compensation Board, Centralized Mailing, PO Box 5205, Binghamton, NY 13902-5205

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

C-430S (9-16) ESTE RESUMEN ESTÁ ESCRITO EN ESPAÑOL AL DORSO

www.wcb.ny.gov

DECLARACION DE DERECHOS

A TODO EMPLEADO LESIONADO EN EL TRABAJO O QUE SUFRA DE ENFERMEDAD OCUPACIONAL: USTED PUEDE TENER DERECHO A BENEFICIOS DE COMPENSACION OBRERA

1. Usted deberá presentar una reclamación de beneficios dentro del término de dos años del dia en que fue lesionado, a menos que la lesión sea tan pequeña que no requiera tratamiento médico y que no cause interrupción en su jornada de trabajo. Si no radica dentro del término de dos años, puede perder sus derechos a beneficios. Consiga y radique una forma de reclamación (Forma C-3, o VF-3 para bomberos voluntarios, o VAW-3 para empleados voluntarios de ambulancias) en la oficina más cercana de la Junta de Compensación Obrera (direcciones más abajo).

2. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de siete días, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo. (Bomberos voluntarios y Trabajadores de Ambulancia Voluntarios pueden ser compensados desde el mismo dia de su lesión.)

3. Usted tiene derecho a recibir tratamiento médico relacionado con su lesión y debe obtenerlo inmediatamente.

4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obtener tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en esta programa establecida por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.

5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.

6. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podría ser responsable del pago de las facturas.

7. El patrono es responsable de la sustitución y reparación de aquellos implementos médicos que han sido perdidos o se han deteriorado como consecuencia del empleo, sin que importe el que el empleado haya onosufrido lesión (Ej. miembros artificiales, dentadura postiza, espejuelos). Usted tambien tiene derecho a ser reembolsado por medicinas, muletas, o cualquier otro implemento debidamente recetado por su médico y por transportación u otro gasto necesario para ir al médico óalhospital. (Obtenga recibos para justificar gastos.)

8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague al abogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.

9. La compensación se paga inmediatamente, sin esperar por la adjudicación del caso, excepto cuando la reclamación es cuestionada. Si la reclamación es cuestionada en base a que la incapacidad no fue causada por un accidente relacionado con su trabajo ó por una enfermedad ocupacional ó por una lesión en el cumplimiento de su deber como bombero voluntario ó como miembro voluntario del cuerpo de ambulancia, usted puede tener derecho a recibir beneficios por incapacidad (para lesiones fuera del trabajo). Si su reclamación es cuestionada y no está recibiendo beneficios por incapacidad, comuniquese con cualquier oficina de la Junta.

10. Regrese a su trabajo tan pronto pueda. La compensación nunca es tan alta como su sueldo. Si necesita ayuda para regresar al trabajo ó para resolver problemas financieros ó personales por causa de la lesión sufrida, comunicate con la oficina mas cercana de la Junta y solicita hablar con un trabajador social o con un consejero de rehabilitación.

11. Su patrono no puede solicitar que usted le releve de su derecho a compensación, ni puede descontar cantidad alguna de su paga para contribuir al pago de las primas del seguro. Usted no podrá ser despedido ni penalizado por radicar una reclamación en la Junta.

SI TIENE DIFICULTAD EN CONSEGUIR UN FORMULARIO DE RECLAMACIÓN O NECESITA AYUDA PARA LLENARLO Ó TIENE DUDAS SOBRE CUALQUIER SITUACIÓN RELACIONADA CON UNA LESIÓN O ENFERMEDAD COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA.

Este resumen es una compilación de los puntos más importantes de sus derechos bajo la ley de compensación obrera. La sección 110 de la ley requiere de su patrono ofrecerle esta información.

Insurance Carrier Name -

Address - PO BOX 881716, San Francisco, CA 94188

Phone- (800) 661-6029 Fax - (415) 675-546

PRESIDENTE
WORKERS' COMPENSATION BOARD

NYS Workers' Compensation Board, Centralized Mailing, PO Box 5205, Binghamton, NY 13902-5205

Berkshire Hathaway HOMESTATE COMPANIES

P.O. BOX 881716 • SAN FRANCISCO CA 94188 • TOLL FREE: (800) 661-6029 • FAX: (415) 675-5469

Per 12 NYCRR 300.26, beginning July 1, 2021, recovering workers have the right to have workers' compensation benefit checks and/or proceeds from a settlement agreement directly deposited into a bank account of their choosing.

Included is the Direct Deposit Authorization Form (DD-1) with additional information and instruction.

Upon notice of a work related injury, please provide the two page form to the recovering worker for his/her consideration.

If you or the recovering worker have questions, please contact our Customer Care Center at 888-495-8949.

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

DIRECT DEPOSIT AUTHORIZATION FORM

Directions: To begin, change, or cancel the transmittal of workers' compensation benefit checks and/or proceeds from a settlement agreement pursuant to WCL § 32 (hereinafter settlement proceeds) directly to a financial institution, fill out this form and submit the form to:

Berkshire Hathaway Homestate Companies
PO Box 881716
San Francisco, CA 94188

Or

Fax to (415) 675-5469

CLAIMANT'S RIGHTS TO DIRECT DEPOSIT

- This form is optional, but you have the right to receive your workers' compensation indemnity benefits or death benefits in the form of direct deposit. You also have the right to receive your workers' compensation indemnity benefits or death benefits by paper check in the mail.

- You have the right to cancel the direct deposit at any time by checking the appropriate box on this form and forwarding the completed form to Berkshire Hathaway Homestate Companies. The request will be implemented within forty-five days of receipt of notice, and thereafter payment of benefits will be sent by paper check.

- Beginning July 1, 2021, you have the right to have such payments deposited into at least two bank accounts at your request, either as a percentage of the total benefit or a fixed dollar amount for each deposit. Berkshire Hathaway Homestate Companies may require a minimum amount of up to $20 into each bank account.

AUTHORIZATIONS & UNDERSTANDINGS

- I authorize Berkshire Hathaway Homestate Companies to directly deposit my workers' compensation indemnity benefits or death benefits into the specified bank account(s).

- I authorize Berkshire Hathaway Homestate Companies to debit the account to recover any credits deposited in error. Berkshire Hathaway Homestate Companies may recover credits deposited in error by any lawful means. IMPORTANT: This consent does not authorize Berkshire Hathaway Homestate Companies to recover alleged over payments of established and awarded benefits.

- I understand that any change in my employment status may affect my right to receive benefits.

- I understand that any false statement or failure to disclose a material fact to obtain or increase my benefits may result in criminal prosecution, disqualification from benefits, and repayment of any funds deposited to my account.

- I understand that the failure to notify Berkshire Hathaway Homestate Companies of any change in financial institution or account may delay receipt of my benefits or settlement proceeds.

- I understand that to change or cancel the direct deposit for my workers' compensation indemnity benefits or death benefits, I need to submit this form to Berkshire Hathaway Homestate Companies.

- I understand that I have an obligation to immediately notify Berkshire Hathaway Homestate Companies if I am no longer entitled to such payments, or of changes in circumstances which affect my entitlement to such payment.

- I understand that Berkshire Hathaway Homestate Companies may require me to certify annually that I continue to elect the receipt of such benefits by direct deposit, and that if I fail to do so, Berkshire Hathaway Homestate Companies may discontinue direct deposit and thereafter provide benefits by paper check.

NEW YORK STATE | Workers' Compensation Board

DIRECT DEPOSIT AUTHORIZATION FORM

Do not send to the Workers' Compensation Board.

☐ **NEW ENROLLMENT** ☐ **CHANGE** ☐ **CANCEL**

SECTION 1 (TO BE COMPLETED BY CLAIMANT)

Depositor/Claimant's Name (last, first):	**WCB Claim Number**:
Phone Number (including area code):	**E-mail Address**:
Address:	

DEPOSITOR/CLAIMANT/JOINT ACCOUNT HOLDER CERTIFICATION

I certify that I am entitled to receive the underlying compensation payments or death benefits and circumstances entitling me to benefits or death benefits have not changed. I understand that Berkshire Hathaway Homestate Companies may request an annual certification of continued entitlement to such payments or benefits and that such certification must be provided within sixty days to continue payments by direct deposit.

Depositor/Claimant Certification Signature	**Date**
Joint Account Holder Certification Signature	**Date**

SECTION 2

Please check with your financial institution to complete the requested information in this section. Direct deposit is only available if your financial institution is part of the New York State Automated Clearinghouse. In addition, the depositor's name MUST appear on the account.

Name of Financial Institution:	**Account Type**: ☐ Checking ☐ Savings Amount or Percentage to be deposited: _____
Depositor's Account Number (EFT Format):	**Routing Number**:

Name of Second Financial Institution:	**Account Type**: ☐ Checking ☐ Savings Amount or Percentage to be deposited: _____
Depositor's Account Number (EFT Format):	**Routing Number**:

Berkshire Hathaway HOMESTATE COMPANIES

Authorization for the Release of Information
Autorización Para La Liberación De Información

Claim Number/Número de Reclamo

Date of Injury / Fecha de la Lesión

Employee/Empleado

Date of Birth / Fecha de Nacimiento

I hereby authorize the divisions of Berkshire Hathaway Homestate Companies, their representative or bearer, to review, inspect, copy, and/or photograph any and all of the following documents:

Por este medio autorizo las divisiónes de Berkshire Hathaway Homestate Companies, su representante o portador, a revisar, inspeccionar, copiar, y/o fotografiar cualquier y todo de los siguientes documentos:

1 Any and all medical records, including but not limited to office and hospital records, laboratory results, diagnostic reports and films, psychiatric records, medical correspondences, doctor's and nurse's notes, and medical histories relevant to my workers' compensation claim. I also hereby give permission to Berkshire Hathaway Homestate Company representatives to contact the attending physicians involved in the treatment of all related conditions.

Cualquier y todo expediente médico, incluyendo pero no limitado, a los expedientes de la oficina y hospitales, resultados de laboratorios y filminas, expedientes psiquiátricos, correspondencia médica, notas de los doctores y enfermeros(as), e historiales médicos relevantes a mi reclamo de compensación de trabajadores. También, por este medio le doy permiso a los representantes de Berkshire Hathaway Homestate Company para comunicarse con el médico tratante envuelto en el tratamiento de todas las condiciones relacionadas.

2 All employment and human resource information including but not limited to: hiring and employment records, payroll and income statements, documentation related to this or any other relevant injury and any other information pertinent to providing benefits and services necessary for the completion of this claim.

Toda información del empleo y de recursos humanos, incluyendo pero no limitado a: expedientes de contratación y empleo, declaraciones de nómina e ingresos, documentación relacionada a esta o cualquier otra lesión relevante, y cualquier otra información pertinente que provea los beneficios y servicios necesarios para completar este reclamo.

The released information is required for the following reasons:

La información liberada es requerida por las siguientes razones:

1 To provide for adequate preparation, investigation, evaluation, review, and discovery of a claim for workers compensation benefits. Specifically, to determine the causation and the nature and extent of any possible pre-existing, concurrent or aggravating medical conditions with potential medical, legal, or factual implications in the this work-related injury or injuries.

Para proporcionar una preparación, investigación, evaluación, revisión, y descubrimiento adecuado del reclamo de beneficios de compensación de trabajadores. Específicamente, para determinar la causa y la naturaleza y extensión de cualquier posible condición médica pre-existente, concurrente o agravante con potencial médico, legal, o implicaciones fácticas en esta lesión o lesiones relacionadas al trabajo.

2 To provide the treating physician, consultant or evaluator with medical information necessary to provide you with the best possible medical care and medical advice.

Para proporcionar al médico tratante, consultor, o evaluador con la información médica necesaria para proporcionarle el mejor cuidado médico posible y consejería médica.

3 To facilitate recovery of all benefits paid toward your workers' compensation claim from any third party responsible for this injury.

Para facilitar la recuperación de todos los beneficios pagados por su reclamo de compensación de trabajadores de cualquier tercer parte responsable de esta lesión.

4 To ensure that you are accurately compensated for any amount of lost wages, time or resources while undergoing evaluation, treatment and recovery for this injury.

Para asegurar que usted se encuentra compensado correctamente por cualquier cantidad de salarios, tiempo, o recursos perdidos mientras se somete a la evaluación, tratamiento, y recuperación de esta lesión.

5 To obtain any information necessary to appropriately determine further actions as a result of the injury or condition and to prevent further issues for you and other employees.

Para obtener cualquier información necesaria para determinar apropiadamente acciones adicionales como resultado de la lesión o condición, y para prevenir problemas adicionales para usted y otros empleados.

6 This consent and authorization is effective immediately, and is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall terminate on conclusion of the claim without express revocation.

Este consentimiento y autorización es efectivo inmediatamente, y está sujeto a la revocación del abajo firmante en cualquier momento excepto a la extensión en que se hayan tomado acciones en dependencia con esto de aquí en adelante, y si no es revocado anteriormente, terminará con la conclusión del reclamo si no se presenta una revocación expresa.

A copy or fax is as valid as the original.

Una copia o fax es tan válida como el original.

Names, Addresses, and Phone Numbers of Providers/Nombres, direcciones, y números de teléfonos de los proveedores

I have read this authorization and fully understand its entire contents. I have asked questions about anything that was not clear to me and I am satisfied with the answers I have received. I understand that I have a right to receive a copy of this authorization upon my request.

He leído esta autorización y entendido completamente su contenido en su totalidad. He hecho preguntas sobre todo lo que no estaba claro para mí y estoy satisfecho con las contestaciones que he recibido. Yo entiendo que tengo derecho a recibir una copia de esta autorización una vez lo solicite.

Signature/Firma

Date/Fecha

Print This Form/ Imprimir Formulario

Berkshire Hathaway HOMESTATE COMPANIES

Medical History Request

Employee Name

Date of Injury

Employer Name

Completion Date

Please complete this form by providing your medical history for the past 5 years. This will help ensure that we are able to provide all of your medical records to your current treating physician for you to receive the proper care for your work injury.

Thank you for your cooperation.

Past Injuries, Disabilities, or Other Medical Conditions

Hospitalizations

Hospital Name & Address	Phone	Date(s) Adimitted

Treating Physicians or Groups

Doctor or Group Name, Address	Phone	Dates of Treatment

Reset Form

Print This Form

Representing Financial Strength & Integrity • Workers Compensation Division

Berkshire Hathaway HOMESTATE COMPANIES

Employee Accident Report

This for should be filled out by the injured employee.

Name

Employer Name

Date of Accident

Time of accident

Time you began work on day of accident

Address of Accident

City, State

Zip

Offsite? (Y/N)

Yes or No

How did the injury occur? What job duties were you performing? Please describe in your own words.

What part(s) of your body was injured (indicating right and/or left)?

Have you sought any medical treatment for these injuries? If so, specify where and when.

Have you ever injured this part of your body before (yes or no)? If so, please describe how and when the previous injury(s) occurred.

What witnesses were present when the accident occurred? Please provide names if applicable.

Who did you report the injury to? When was the injury reported? Please provide name(s) and job title(s).

What did you do after the accident occurred?

The above form is true and correct.

Signature

Date Completed

Reset Form

Print This Form

Berkshire Hathaway HOMESTATE COMPANIES

Informe De Accidente Del Empleado

A ser completado por el trabajador lesionado.

Nombre del empleado

Nombre del empleador

Fecha del accidente

Hora del accidente

Hora en que usted empezó a trabajar el día del accidente

Ubicación del accidente (especifique si es una dirección fuera del sitio)

¿Cómo ocurrió la lesión? ¿Qué deberes del trabajo estaba desempeñando? Por favor, describa en sus propias palabras.

¿Qué parte(s) de su cuerpo resultó(aron) lesionada(s) (indicando derecha y/o izquierda)?

¿Ha buscado algún tratamiento médico para estas lesiones? Si es así, especifique dónde y cuándo.

¿Se ha lesionado anteriormente alguna vez esta parte de su cuerpo (sí o no)? Si es así, por favor, describa cómo y dónde ocurrió(eron) la(s) lesión(es) anterior(es).

¿Qué testigos estuvieron presentes cuando ocurrió el accidente? Por favor, proporcione nombres si es aplicable.

¿A quién informó la lesión? ¿Cuándo fue informada la lesión? Por favor, proporcione nombre(s) y puesto(s).

¿Qué hizo después de ocurrido el accidente?

El informe anterior es verdadero y correcto.

Firma

Fecha En Que Se Completó El Formulario

Restablecer formulario

Imprimir Formulario

Berkshire Hathaway HOMESTATE COMPANIES

Supervisor's Report of Employment Accident

Employee Name

Employer Name

Date of Accident | Time of accident | Time you began work on day of accident

Did the employee report the accident immediately? Yes or No

Address of Accident | City, State | Zip | Offsite? (Y/N) Yes or No

How did the injury occur? What job duties were you performing?

What part(s) of the employee's body were reported as injured?

Has the employee sought any medical treatment for these injuries? If so, specify where and when.

What witnesses were present when the accident occurred (including self)?

Do you have any reason to question the legitimacy of the accident? If so, please explain:

Berkshire Hathaway HOMESTATE COMPANIES

Supervisor's Report of Employment Accident

Indicate working conditions present that led to accident (please check all that apply)

- ☐ Unused/unavailable lifting equipment
- ☐ Unused/unavailable PPE (gloves, hardhat, goggles, etc.)
- ☐ Unused/unavailable sharps container
- ☐ Unguarded or improperly guarded equipment
- ☐ Electrical exposure
- ☐ Obstructed view
- ☐ Lack of training
- ☐ Wet/slippery floor
- ☐ Poor housekeeping
- ☐ Interaction with co-worker
- ☐ Interaction with patient or resident
- ☐ Interaction with customer
- ☐ Chemical exposure
- ☐ Motor vehicle accident
- ☐ Other:

What changes could be made to eliminate or reduce the hazard(s) identified above?

The above form is true and correct.

Prepared by

Signature

Date Completed

Reset Form

Print This Form

Berkshire Hathaway HOMESTATE COMPANIES

Informe Del Supervisor De Accidente De Empleado

Nombre del empleado

Nombre del empleador

Fecha del accidente

Hora del accidente

Fecha en que se informó el accidente

¿Informó el empleado el accidente inmediatamente? Si/No

Ubicación del accidente (especifique si es una dirección fuera del sitio)

¿Cómo ocurrió la lesión? ¿Qué deberes del trabajo estaba desempeñando el empleado?

¿Qué parte(s) del cuerpo del empleado se informaron como lesionadas?

¿Ha buscado el empleado algún tratamiento médico para estas lesiones? Si es así, especifique dónde y cuándo.

¿Qué testigos estuvieron presentes cuando ocurrió el accidente (incluyendo él mismo)?

¿Tiene usted alguna razón para dudar de la legitimidad del accidente? Si es así, por favor, explique:

Berkshire Hathaway HOMESTATE COMPANIES

Informe Del Supervisor De Accidente De Empleado

Indique las condiciones de trabajo presentes que conllevaron al accidente (por favor, marque todas las que apliquen).

- ☐ Equipo para levantar no usado/no disponible
- ☐ PPE (guantes, casco, gafas, etc.) no usado/no disponible
- ☐ Contenedor de objetos punzantes no usado/no disponible
- ☐ Equipo no resguardado o incorrectamente resguardado
- ☐ Exposición eléctrica
- ☐ Vista obstruida
- ☐ Falta de capacitación
- ☐ Herramientas o equipo defectuosos
- ☐ Piso mojado/resbaloso
- ☐ Mala limpieza
- ☐ Interacción con compañero de trabajo
- ☐ Interacción con paciente o residente
- ☐ Interacción con cliente
- ☐ Exposición a producto químico
- ☐ Accidente de vehículo motorizado
- ☐ Other:

¿Qué cambios se pueden realizar para eliminar o reducir el(los) peligro(s) identificado(s) anteriormente?

El informe anterior es verdadero y correcto.

Elaborado por

Puesto

Fecha de elaboración:

Restablecer formulario

Imprimir Formulario

Berkshire Hathaway HOMESTATE COMPANIES

Witness' Report/Statement of Employee Accident

Employee Name

Witness' Name

Witness' Phone Number

Witness' Address

City, State

Zip

Offsite? (Y/N)
Yes or No

Date of Accident

Time of accident

Time you began work on day of accident

Address of Accident

City, State

Zip

Offsite? (Y/N)
Yes or No

Did you witness the above-reported accident? If so, how did the injury occur? What job duties was the employee performing?

What part(s) of the employee's body were injured? Describe the type of injury (strain, bruise, etc.)

What did the injured employee say at the time of injury? Did the injured employee complain of pain at the time of injury? If they complained of pain, please specify the body part(s).

What did the employee do after the accident occurred?

Were any other witnesses present at the time of the accident? If so, please list them below.

The above form is true and correct.

Witness' Signature

Date Completed

Reset Form

Print This Form

myMatrixx
An Express Scripts Company

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed the processing of your approved workers' compensation prescriptions.

Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at 800.945.5951.

Atención Trabajador Lesionado:

En su primera visita, por favor entregue esta notificación a cualquier farmacia enumerada al reverso para acelerar el procesamiento de sus recetas aprobadas de compensación para trabajadores (según las pautas establecidas por su empleador).

Si tiene cualquier duda o necesita ayuda para localizar una farmacia de venta al por menor participante de la red, por favor llame al Centro de Contacto para Atención a Clientes de Express Scripts, al 800.945.5951.

To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 14-day supply or a cost of $150. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call Express Scripts at 888.786.9640.

Pharmacy Processing Steps

Step 1: Enter BIN number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

Express Scripts

ID#: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____/_____/_____
MM/DD/YYYY

G3YA

Group #: _____

Employee Date of Birth: _____/_____/_____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Supervisor: Please fill in the information requested for the injured worker.

Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

_____

Participating Retail Network Pharmacies

myMatrixx
An Express Scripts Company

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Harris Teeter
H-E-B
Hi-School Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
Kroger
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare
Network Pharmaceuticals
Northeast Pharmacy Services
Osco
P & C Food Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target
Texas Oncology Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets
Vons
Waldbaums
Walgreens
Walmart
Wegmans
Weis
Winn Dixie

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

AM BEST A++ Superior

$1000 REWARD

For information leading to the arrest and conviction of any co-worker, health care professional, or the attorney representing a fraudulent workers compensation claim to Berkshire Hathaway Homestate Companies (BHHC)*.

In most states, it is a felony to make or cause to be made a knowingly false or fraudulent material statement in order to obtain workers compensation benefits. BHHC believes that any party engaging in such fraud should be prosecuted to the fullest extent of the law, including jail sentences.

Please do your part to help! Putting criminals out of operation benefits all of us, including keeping your employer's premium rates reasonable.

Call our toll-free fraud hotline immediately if you have information on a fraudulent claim.

1 (800) 300-JAIL

*Maximum reward of $1,000 per conviction. In the event that more than one individual submits information regarding the same fraudulent claim, BHHC will equally divide the reward among those providing information used in obtaining the conviction. BHHC reserves the right to determine what information, if any, will be provided to the appropriate law enforcement agency. Criminal prosecutions are the sole responsibility of the authorities and may or may not be pursued at their discretion. Any issues regarding the interpretation of this policy shall be resolved by BHHC at their sole discretion. Program subject to change or termination without prior notice.

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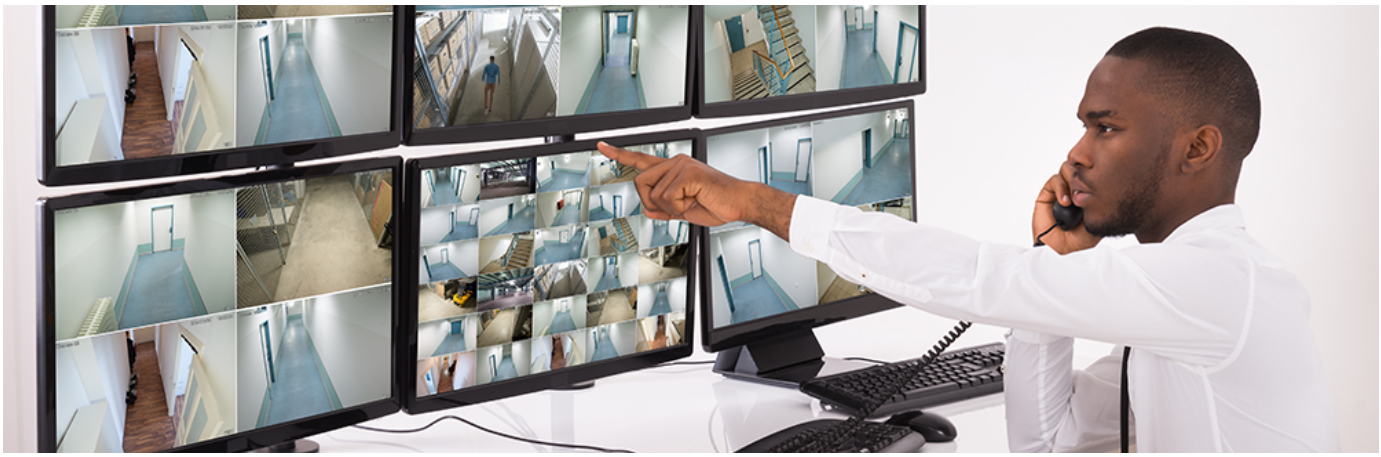
F.ENG.21.1.7.2

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

AM BEST A++ Superior



$1000 RECOMPENSA

Información que lleva al arresto y a la condena de cualquier compañero de trabajo, profesional de cuidado medico, o abogado que represente un reclamo fraudulento en contra de Berkshire Hathaway Homestate Companies*.

En la mayoría de los estados es un delito grave hacer que haga una declaración de material fraudulento para obtener beneficios de Compensación al Trabajador. Berkshire Hathaway Homestate Companies cree que cualquier persona que se involucre en tal fraude debe ser procesado con todo el rigor de la ley, incluyendo SER SENTENCIADO A LA CARCEL.

Ayúdenos de su parte. El poner a estos delincuentes fuera de op eraciones nos beneficia a todos, incluso esto ayuda a mantener los réditos bajos de la as eguranza de su empleador.

Si usted tiene información sobre un reclamo fraudulento por favor llame de inmediato a nuestra LINEA GRATUITA DE FRAUDE.

1 (800) 300-JAIL

*La recompensa máxima es de $1,000 por convicción. En caso de que más de una persona presente informaciones sobre la misma demando fraudulenta. BerkshireHathaway dividirá la recompensa por partes iguales entre aquellas persones que aportaron informaciones para obtener la convicción. Berkshire Hathaway se reserva el derecho de determinar qué informacion presentará a la agencia judicial correspondiente. El proceso de crímenes es la responsibilidad exclusiva de las autoridades, que pueden decidir si el proceso debe entablarse or no. Cualquier disputa que pudiera surgir en la interpretación de esta ofreta será resuelta por la propia Compañia de Seguros Berkshire Hathaway. Este programa está sujeto a cambios a cancelación sin aviso previo.

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FSP.21.1.7.4