



# ***Comp Alliance Member Abbreviated Client Service Kit for Home Use***

**Program Sponsor**



**Program Manager**



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[www.compalliance.org](http://www.compalliance.org)

Gerald K. Geist  
Chairman

Michael E. Kenneally  
Executive Director

## Comp Alliance Service Update During Coronavirus Pandemic

Dear Comp Alliance Members:

Given the spread of the COVID-19/Coronavirus virus, we want to assure our Comp Alliance Members that we are taking your employee health, community health, and that of our staff as a top priority. We want to assure all clients of the Comp Alliance that we are working diligently to meet the extraordinary challenges presented by the Coronavirus. In order to ensure the protection of our own employees, we are currently working with most of our staff remotely.

These employees have access to all our computer systems, claim files, and email. Phone calls to their desk phones are being electronically routed to their home or cell phones in real time. Our claim examiners will be able to perform 100% of the functions they normally perform at our office. In addition we will continue to have key staff members in the office to perform essential functions, including check printing, to ensure that all payments to injured employees and services providers are made on an uninterrupted basis.

We have developed a **condensed version of our Client Service Kit** which includes the essential information for filing a claim as well as the contacts for our service team. We hope you find this information useful in the event you need it at home during the duration of this pandemic. Members can also check our website by visiting [www.compalliance.org](http://www.compalliance.org) for updates and emergency measures from the Workers' Compensation Board on claims protocols and other related news.

As you are aware the Comp Alliance is a service focused program performing many regional safety seminars throughout the state. With the health of all communities throughout New York State in mind and to help slow and minimize the spread of the virus our seminars over the next month are currently postponed and we are working to reschedule many of these later in the year.

Please visit our events calendar located at <https://www.compalliance.org/events/calendar.html> for a complete updated listing of seminars and conferences that have been cancelled and postponed as well as our reschedules as they are made. In the meantime if you have immediate training needs or would like to proactively enhance your safety efforts please visit our member exclusive safety training center located at <https://www.compalliance.org/>.

Within the Comp Alliance Academy we currently have 30 safety training courses, several safety webinars, and safety bulletins. Members can also now access the Safety Source video library. Members who wish to access more than 850 free safety training videos can send their request to [sroes@wrightinsurance.com](mailto:sroes@wrightinsurance.com)

Rest assured, we are actively monitoring this evolving situation and are here to work with each program member and continue to provide the best possible workers' compensation service. We urge all program members to exercise caution and watch for further guidance.

Stay Safe,

**Comp Alliance Service Team**



**Plan Manager: Wright Risk Management**  
900 Stewart Avenue, Suite 600, Garden City, NY 11530  
Phone: 866-697-6922 Fax: 516-227-2352





# ***WELCOME***

*On behalf of all the members of the Comp Alliance, the Association of Towns of the State of New York, the New York State Conference of Mayors and the staff here at Wright Risk Management supporting the Comp Alliance program, we would like to formally welcome you into the Comp Alliance.*

*As a member of the Comp Alliance, you have access to each and every dedicated professional supporting the program. We've provided a complete listing of direct phone numbers and email addresses for our staff, and encourage you to contact us immediately should any questions or concerns arise.*

*We look forward to working with you and your employees, and thank you for trusting the New York State Municipal Workers' Compensation Alliance with your Workers' Compensation needs.*

*Sincerely,*

*Eric Hartcorn  
Program Manager*



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**NYS Municipal Workers' Compensation Alliance**

900 Stewart Ave., Suite 600

Garden City, NY 11530

Toll Free Phone Number: (866) 697-6922

Fax Number: (516) 227-2352

**TOLL FREE DEDICATED FAX LINE FOR CLAIM REPORTING: (877) 567-5730**

**E-MAIL FOR CLAIM REPORTING: [wcreporting@wrightinsurance.com](mailto:wcreporting@wrightinsurance.com)**

## **CONTACT LIST**

### **Claims Management Services:**

Catherine Mayne, Claims Examiner <a href="mailto:cmayne@wrightinsurance.com">cmayne@wrightinsurance.com</a>	(516) 750-3927
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**INFORMATION IS JUST A CLICK AWAY FOR MEMBERS!**

**[www.compalliance.org](http://www.compalliance.org)**

BE SURE TO REGISTER FOR OUR MEMBERS ONLY WEBSITE BY  
EMAILING YOUR REQUEST TO [sroes@wrightinsurance.com](mailto:sroes@wrightinsurance.com)

### The Members Only Website Provides:

- Safety Training Videos (including DOL and PESH mandated training topics workplace violence, bloodborne pathogen, and right to know)
- Municipal and School Specific Safety Courses
- Safety Webinars
- Access to Safety Source Video Library
- Monthly Safety Bulletins
- E-Newsletters
- Member Correspondence
- Events Calendar
- Annual Membership Reports
- Common Claim Filing and Assessment Reporting Forms



## CLAIM HANDLING PROTOCOLS

1. When an accident occurs, you should prepare the C-2F (Employer's report of accident) and forward the original to the New York State Municipal Workers' Compensation Alliance (Comp Alliance) **via fax to: 877-567-5730 or via email to: [wcreporting@wrightinsurance.com](mailto:wcreporting@wrightinsurance.com)**  
The Comp Alliance will review the C-2F and determine whether it is necessary to file the claim with the Workers' Compensation Board, based on the W.C. law.
2. We also provide you with Workers Compensation ID Cards to give your employees, so that your employee's medical provider is aware that this is a workers' compensation accident that fees must be billed at the applicable fee schedule and bills should be forwarded directly to the Comp Alliance for processing.
3. We will investigate the accident promptly to determine if it is compensable. This investigation may call for us to speak directly with the injured employee and his/her medical provider. Once this investigation has been obtained, it is reviewed with a highly experienced Account Manager to determine if it should be accepted.
4. The Comp Alliance will communicate with you to verify if the injured employee is still out of work, if he/she is entitled to and receiving full wages, or whether an income replacement (indemnity) payment should be issued. If a workers' compensation payment is in order, we will issue a payment directly to your employee.
5. In some cases, we will ask you to complete a C-240 Wage Statement and forward it to us. This information helps us to ensure that your employee's Average Weekly Wage (AWW) is promptly and correctly calculated by the W.C. Board.
6. When an injured employee returns to work (or leaves work again), please call us immediately and record this on a C-11 (Change in Employment Status) form.
7. In the event of cases wherein the claimant receives full wages during the period of compensable lost time, the Comp Alliance will request the municipality to complete a Reimbursement Request.
8. All other required Workers' Compensation filings will be prepared by us with a copy sent to you.
9. Municipal personnel responsible for the administration of workers' compensation claims should provide pertinent information regarding claims to the Comp Alliance and cooperate with the Comp Alliance in any matters related to claims.



## Overview of Workers' Compensation

Up until 1914 an employee was able to sue the employer for benefits in connection with an on-the-job injury. This system highly favored the employer in that the cost of litigation had to be borne by the employee. Not many claims filed by employees were successful because litigation would take years and the employer would object to benefits on the grounds that either the injury was caused by the workers' negligence, or that it was caused by the negligence of a fellow worker or that the worker had assumed the risk of employment."<sup>1</sup>

The present workers' compensation law allows for both lost wages and medical treatment. Every employer with one or more employees must provide workers' compensation coverage. Under the current Workers' Compensation Act, an employer is protected in most cases against any lawsuit filed by the employee. The injured employee also has the right to file a lawsuit against a third party (who is not his or her employer), but may have contributed to or caused the accident. It is imperative that we be notified immediately when the employer has any knowledge of a third-party claim filed by an injured employee.

The following criteria must be met in order for a claim to be compensable.

For accidents, which are defined as trauma followed by sudden pain;

- (1) The employee must give written notice to his or her employer within 30 days.
- (2) The injuries sustained from an accident must arise out of and in the course of the employee's employment (causal relationship).
- (3) There must be medical evidence linking the injuries to the accident described (prima facie medical evidence).

For an occupational disease, the above criteria applies but the occupational disease, which is defined as an illness due to either repetitive trauma or repetitive exposure to a substance, must be reported to the employer in writing within 30 days from the date that the illness is diagnosed by a physician.

<sup>1</sup>From *Gould's Workers' Compensation Law Handbook of New York*  
Gould Publications, 1993.



## Filing Accident Reports

**The current C-2F form (Employer Report) and other common claim forms are attached to this document and can also be obtained by visiting [www.wcb.ny.gov](http://www.wcb.ny.gov).** Use this form to report a work-related accident or occupational disease required by the Workers' Compensation Board. When an employee gives notice of a claim, the employer completes this form. All employees should be made aware that they must report any accident in writing in a timely manner to protect themselves and the employer. We suggest that the payroll staffer (included within this document) be used to notify employees of the procedure.

After receiving the internal accident report, the person responsible for completing the C-2F should fill in every space on the C-2F report. If a question is not applicable, indicate it with "N/A". The proper carrier code must be used. This is how the NYS Workers' Compensation Board tracks your particular program. If you do not know your code, please contact us, and we provide it to you.

The date that the injured employee stopped work (Box 7a) should be the first full day out of work. Please stress to the employee that they must state the part(s) of the body affected (Box 13) no matter how minor the injury. Failure to advise us of all affected body parts may cause us to question injury sites and medical treatment at a later date. Every effort should be made to identify the treating physician or hospital involved. If an employee originally did not see a physician for his or her injuries, please note it on the form.

We strongly suggest that C-2Fs be filed for every accident no matter how minor. This provides us with needed information should we receive any medical reports or requests for treatment or diagnostic testing.

A C-2F must be filed within 10 days from the date that the employer first has knowledge of the accident.

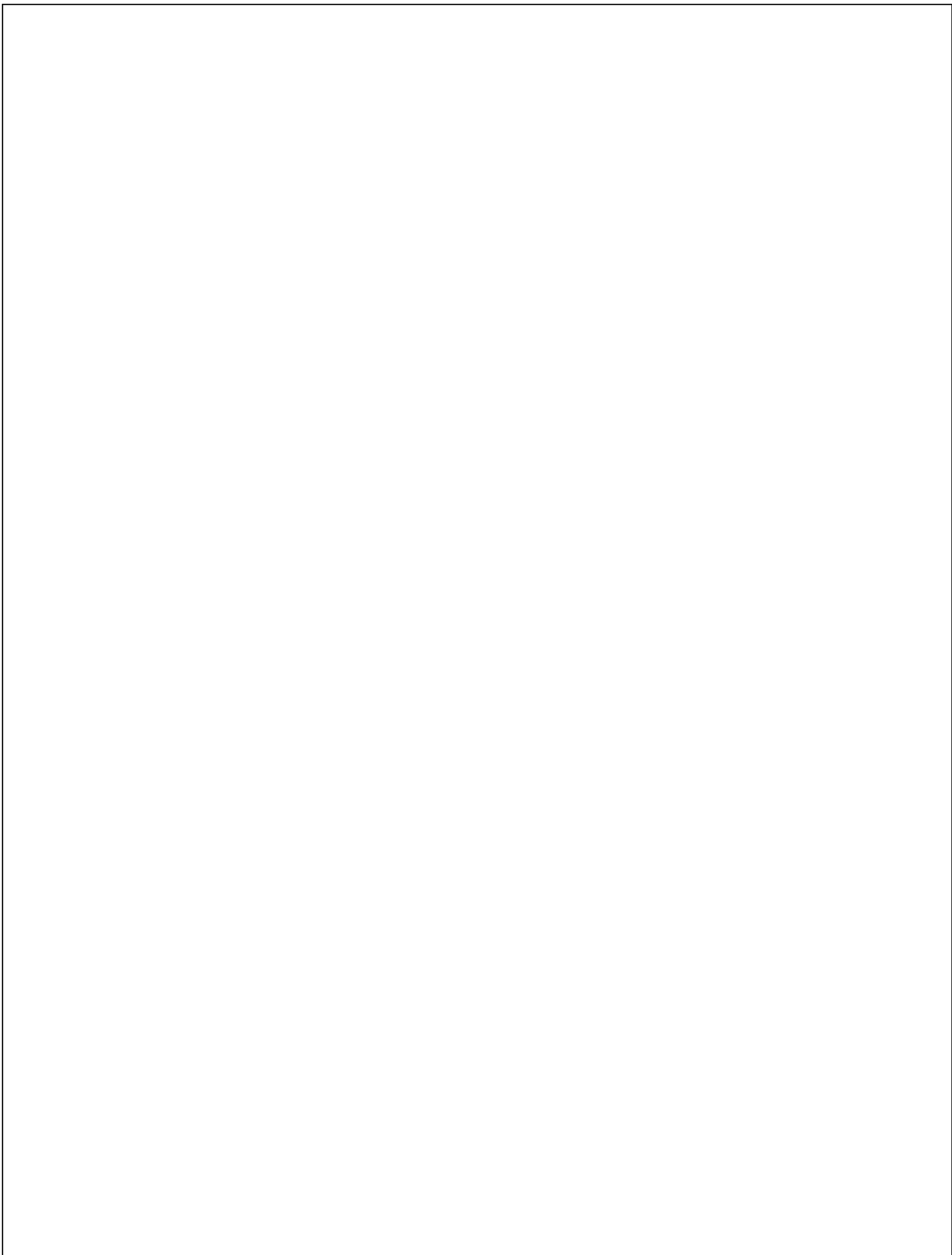
The following penalties may be imposed by the Workers' Compensation Board for late reporting:

“An employer who refuses or neglects to make a report as required by law shall be guilty of a misdemeanor, punishable by a fine of not more than one thousand dollars. The Board or Chair may impose a penalty of not more than two thousand five hundred dollars upon an employer who refuses or neglects to make such a report.”

## Filing of the C-2F

Wright Risk Management will be responsible for filing the C-2F with the New York State Workers' Compensation Board. The following criteria determine if a C-2F must be filed with the Workers' Compensation Board:

- Any accident that results in lost time beyond the working day on which the accident occurred.
- Any accident that causes the need for medical treatment beyond ordinary first aid or more than two treatments by a person rendering first aid.



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

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 \_\_\_\_\_



# You were injured at work. What now?

If you have suffered a workplace injury or illness, you may be eligible for workers' compensation benefits. You may have already received medical treatment. If you haven't, you should seek medical care as soon as possible.

For assistance with your claim, call the **Workers' Compensation Board** at **(877) 632-4996**.

## Your Responsibilities

- You must notify your employer, in writing, when, where and how you were injured. Do this as soon as possible within 30 days of injury.
- Advise your health care providers that you have a work-related injury, and give the name of your employer. Do not pay for your care or use other health insurance. Your health care provider will file medical 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.
- You should file an **Employee Claim** (Form C-3) reporting your injury to the Board 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 **Limited Release of Health Information** (Form C-3.3).

## Two ways to file a Claim

Visit [wcb.ny.gov](http://wcb.ny.gov) and select **File a Claim**.

Complete the enclosed paper form(s) and mail to the Board.

If you have questions about filing an **Employee Claim (Form C-3)**, please call **(877) 632-4996** and a Board representative will assist you.

## Health Care and Travel Bills

**Do not** pay your health care provider or hospital for treatment received for this injury/illness. Those bills are paid by the insurer unless the Board issues a decision that finds your claim is not valid. If your case is disputed, the healthcare providers will be paid if the Board decides your case in your favor. *However, if the Board decides against you, or if you don't pursue a case, you will have to pay the health care provider or hospital (or submit to your health insurance carrier).*

Your employer's workers' compensation insurance covers medically necessary drugs and equipment your health care provider prescribes. You may also be reimbursed for mileage, public transportation or other necessary expenses incurred when traveling for treatment. Make sure that you obtain receipts for those expenses, and submit them to your workers' compensation insurer on a **Claimant's Record of Medical and Travel Expenses and Request for Reimbursement** (Form C-257).

## CLAIMANT INFORMATION PACKET

Generally, you can choose any health care provider as long as the provider is authorized by the Board. You can search for an authorized health care provider in your area using the “**Find a Doctor**” feature on the Board’s website at [wcb.ny.gov](http://wcb.ny.gov). You can also use occupational health clinics. However, if your employer’s workers’ compensation insurer has a Preferred Provider Organization (PPO) to provide care for workers’ compensation injuries, you must get your initial treatment from the PPO network. If that insurer also has a pharmacy or diagnostic network, you must receive services within these networks. The insurer must tell you about its required provider networks and how to use them.

### Benefits for Lost Wages

You are entitled to a portion of your lost wages, which must be paid promptly, if your injury affects you in one or more of the following 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.

You may hire an attorney or licensed representative for help with your claim, but it isn’t required. The Board sets their fees, which 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. To get a **Notice and Proof of Claim for Disability Benefits** (Form DB-450), visit [wcb.ny.gov](http://wcb.ny.gov); call the Board for assistance; or visit a Board office. If the case is resolved in your favor, the disability benefits would be deducted from your lost wages award.

### Help is Available

Sometimes you need help getting back to work. Your employer may have alternative or light duty assignments that enable you to work while you heal. An injury can also cause family or financial problems. The Board has vocational rehabilitation counselors and social workers to help. Call the Board for more information on available services and for assistance.

If you are concerned about dependency on opioid pain medications, please call the NYS OASAS HOPELine at **877-8-HOPENY (877-846-7369)**.

### What’s Next?

Your employer or its workers’ compensation insurance carrier will contact you if your claim is accepted. When that happens, your health care providers will be paid and lost wage benefits begin. If your case is disputed, the Board will notify you about resolving the case and may request additional information if necessary.

## IMPORTANT CONTACT INFORMATION

Workers’ Compensation Board,  
including Disability Benefits

(877) 632-4996

[general\\_information@wcb.ny.gov](mailto:general_information@wcb.ny.gov)

[wcb.ny.gov](http://wcb.ny.gov)



The Board’s eCase application enables you to view the contents of your case folder online. For general information or to register for eCase, please visit the Board’s website at [wcb.ny.gov](http://wcb.ny.gov).



**Workers’  
Compensation  
Board**



# Employee Claim

## State of New York - Workers' Compensation Board

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](http://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/Apartment No. 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: \_\_\_\_\_  
First MI Last

DATE OF INJURY/ILLNESS: \_\_\_\_/\_\_\_\_/\_\_\_\_

**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: \_\_\_\_/\_\_\_\_/\_\_\_\_



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 \_\_\_\_\_



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 representante legal del 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 áreas 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 Address (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)

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

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

## Instructions for Completing Employee Claim (Form C-3)

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

In Section A, enter your name, address and other requested information.

**Note on Item 7:** Board hearings are conducted in English. If you need a translator, select **Yes** and indicate the language needed.

#### Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 552a).

The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

### Section B - Your Employer(s):

In Section B, enter the name, address, phone number and other information of the employer you were working for at the time of the injury/illness.

**Note:** Your employer is the company or agency that issues your paycheck. If you are a contractor at a work site or office, the staffing agency or vendor who hired you is your employer, not the work site or office where you report to work.

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

In Section C, enter your job title, work activities and pay information.

### Section D - Your Injury or Illness:

In Section D, enter your injury or illness information.

**Item 1:** Enter the date you were injured or the first date you noticed you became ill.

If this is an illness or occupational disease, skip item 2. The date you were injured must be in month/day/year format. The year should be written as four digits, e.g., 2015.

**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 the date you stopped working. If you have not stopped working, check No and skip to the next section.

**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 nearest Workers' Compensation Board Office. (See below.) 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, telephone or visit the nearest Workers' Compensation Board Office listed below.
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**