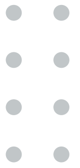

Sedgwick Claims Kit

New York

R&Q ACCREDITED
PROGRAM MANAGEMENT

P.O. Box 14779
Lexington, KY 40512
Toll Free: 866-738-9201
Fax: 859-280-3275

Dear Insured:

We would like to welcome you as a policyholder of Accredited Casualty and Surety Company. Sedgwick is your Claims Administrator, and we are pleased to be able to provide you with workers' compensation claims handling services. Please follow the below instructions for filing a new claim and note the claim kit attachments.

Where do I report a claim?

- Phone: 855-728-5277 (855-7ATLAS)
- Email: 6200AtlasGeneralInsurance@sedgwick.com
- Fax: 866-383-3296

Create your medical panel card to display for your employees:

- **Website:** www.sedgwickproviders.com/AG
- Select "Create Panel"
- Add your business name and work location address
- Select "Create Panel"
- Place "Accredited Surety and Casualty Company, Inc." in box for insurance coverage
- Select "Create Panel" (One panel will be needed for each work location)

Claim Kit Attachments:

- Your Responsibilities as an Employer flyer
- Advocate for Business flyer
- Instructions for Completing Form C-2F
  Claimant Information Packet
- Employee Claim – Form C-3 & Instructions for Completion
- Express Scripts first fill temporary pharmacy card and participating pharmacies

For additional information please visit the NYS Workers Compensation Board at *www.wcb.ny.gov*

Need a loss run?

- Email: RPS.SanDiego-2.LossRuns@rpsins.com

Have more questions?

Contact the Atlas Customer Care Team at Sedgwick - One of our friendly Client Services Associates will be happy to assist you.

- Phone: 866-738-9201
- Email: AtlasTeam@Sedgwick.com

We appreciate your business and believe that communication is critical for successful claims administration. We encourage you to contact us if you have any questions.

www.Atlas.us.com

Your Responsibilities as an Employer

Reporting Injury and Illness

When a workplace injury or illness occurs, employers are required under ***Section 110*** of the ***New York State Workers' Compensation Law*** to report the incident to their insurance carrier (insurer) in a timely manner.

Timely reporting of a workplace injury or illness:

- Allows the injured worker to receive treatment and benefits promptly,
- Has been shown to reduce the costs of a claim,
- Helps the insurer monitor and administer the claim, and
- Ultimately leads to the injured worker returning to work faster.

How soon must employers report a workplace injury or illness?

Employers should notify their insurer immediately if the injury or illness:

- Caused (or will cause) the worker to lose time from regular duties beyond the working day or shift on which the injury occurred.
- Required (or will require) the worker to receive medical treatment beyond ordinary first aid, or more than two treatments of first aid.

Insurers or claims administrators must report a work-place injury or illness to the New York State Workers' Compensation Board on or before the 18th day after the workplace injury or illness occurred, or within 10 days after the employer learns of the event — whichever period is greater.

If an employer does not notify the insurer/claims administrators within this timeframe, it can prevent timely reporting to the Board — causing a delay in the injured worker's claim.

How do employers report a workplace injury or illness?

Employers should notify their workers' compensation insurer or claims administrator immediately of also be notified. The employer's insurer or claims administrator may report the injury to the Board, or the employer can notify the Board directly by filing the *Employer's Report of Work-Related Injury/Illness (Form C-2F)*. However, this is not required if your claim administrator or insurer reports on your behalf.

Is there a penalty for untimely reporting?

YES. Employers should notify their insurer or claim administrator immediately of a workplace injury or illness as penalties of up to $2,500 for late or missing reports are possible.

Can employers challenge a claim?

Employers can request that the insurer challenge the compensability of a claim, where appropriate. An employer can challenge a claim for a variety of reasons including:

- The injury did not occur at work
- The employer did not employ the worker
- The claim is fraudulent

Questions?

To learn more, call **(877) 632-4996** or visit **wcb.ny.gov.**

NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

ADVOCATE FOR BUSINESS

The Advocate for Business is the liaison between New York's business community and the Workers' Compensation Board, giving employers one place to contact for answers to their workers' compensation questions. The Advocate for Business:

- **Assists businesses with insurance coverage problems and compliance with the Workers' Compensation Law;**
- **Educates employers and government personnel on how the workers' compensation system works and their responsibilities; and**

328 State Street
Schenectady, NY 12305
1-877-632-4996
AdvocateBusiness@WCB.NY.Gov

The Advocate for Business offers educational presentations on topics important to business, such as an employer's responsibilities and insurance requirements, as well as reducing premiums and penalties.

Call or email to schedule a presentation.

- **Meets with business associations and employer groups to hear their workers' compensation concerns, report those issues to the Chair of the Workers' Compensation Board, and offer solutions.**

The Advocate for Business works with employers of all sizes in all industries, particularly small business owners, with issues they've been unable to resolve elsewhere.

Contact the Advocate for Business for information about your business and workers' compensation:

1-877-632-4996

When calling, please have the following information

- **Complete Corporate Name Contact Person, Phone**
- **Number and Email Address Insurer and Policy Number**
- **Federal Employer Identification Number or WCB Employer Number**

Brief Description of the Problem and any Correspondence Received

INSURANCE MUST BE PROVIDED FOR:
Workers in all for-profit businesses
Domestic workers, sitters, companions and live-in maids employed 40 hours per week in a residence
Farm workers whose employer paid $1,200 or more for farm labor in the preceding calendar year
Most workers compensated by a nonprofit organization
Any other worker the Workers' Compensation Board determines is an employee

WHO DOES NOT NEED INSURANCE:
Sole proprietors
Individuals in partnerships
Individuals in one- and two-person corporations where the individual(s) owns all stock (at least one share each in two-person corporations) and holds all corporate offices if the corporation has no employees

Business owners can always include themselves on a policy.

When an Incident Occurs

When a workplace accident occurs, the employer should:

- **Immediately report the accident to the insurer;**
- **Investigate the cause of the accident; and**
- **Correct safety hazards.**

Employers can also stay in touch with the injured worker during recovery. Benefits for lost wages must begin within 18 days of injury or 10 days of notice, whichever is later. Late accident reporting can cause benefits to begin later than the allowed time frame, which can result in penalties. Studies show prompt reporting of an incident and timely benefits ultimately reduce workers' compensation costs.

Employers Must Carry Workers' Compensation and Disability Insurance

Workers' compensation insurance provides benefits for employees injured at work and also protects employers from liability. Employers who fail to carry workers' compensation and disability insurance face financial penalties; criminal and civil penalties are also possible. There are also penalties if an employer intentionally and materially:

- **Understates or conceals payroll.**
- **Misrepresents or conceals employee duties to avoid a proper classification for premium calculation.**

The Board may issue a stop-work order to any employer operating without required workers' compensation coverage, or who fails to pay penalties (except if the failure concerns only domestic or child care workers). When the employer secures insurance and enters a payment plan with the Board, a conditional release from a stop-work order is possible.

The Advocate for Business offers presentations on topics important to business such as an employer's responsibilities and insurance requirements. To schedule an educational session, call 1-877-632-4996 or email AdvocateBusiness@WCB.NY.Gov

NEW YORK STATE Workers' Compensation Board

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 Accredited Surety and Casualty Company **Insurer ID** ______________________

Name Sedgwick

Info/Attn ______________________

Address PO Box 14779

City Lexington **State** KY

Postal Code 40512 **Country** USA

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 No Yes

Employer Paid Salary in Lieu of Compensation LYes N o

Initial Treatment No Medical Treatment

Minor On-Site Treatment By Employer Minor Clinic/Hospital Treatment

Hospitalization Greater Than 24 Hours HFuture Major Medical/Lost Time Anticipated

7

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 ____________________

Initial Date Disability Began ____________________

Initial Return to Work Date

Return To Work Type

Physical Restrictions

Releas ed Y e s N

Return To Work Same Employer

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

Manual Classification Code

UI Number

Industry Code

Info/Attn

Mailing

State

Address City

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:

Date

Signature of Person Preparing Form

Print Name

Title ______________________ Phone Number ______________________

State of New York – Workers' Compensation Board

Instructions for Completing Form C-2F
"Employer's First Report of Work-Related Injury/Illness"

Enter the name of the injured employee at the top of the report. Fill out the Date of Injury/Illness, to the best of your knowledge. If you do not have or know the Workers' Compensation Board Case Number or Claim Administrator Claim Number, please leave the corresponding field blank. It is not required to process the form.

Insurer / Claim Administrator Information:

- **Insurer Name** – the name of your Workers' Compensation Insurer or Self-Insured Group name.
- **Insurer ID** – Carrier Code Number (**W** Number) issued by the Workers' Compensation Board. If you do not know the **W** number, contact your insurer.
- **Name** – the name of the Claim Administrator (claim adjusting office handling the claim).
- **Info/Attn** –any additional pertinent contact information for the Claim Administrator.
- **Address, City, State, Postal Code, & Country** – address of claims administrator, if known.
- **Claim Admin ID** – Carrier Code Number (**W** Number) or Third Party Administrator Number (**T** Number) issued by the Workers' Compensation Board. If you do not know the Third Party Administrator Number (**T** Number), contact your Claim Administrator.

Employee Information:

- **First Name, Middle Initial, Last Name, Suffix** – the injured employee's full legal name.
- **Mailing Address, City, State, Postal Code, & Country** – the full address of the injured employee.
- **Phone Number** – the employee's phone number including area code.
- **Date of Hire** - the date the employee was hired.
- **Date of Birth** – the employee's date of birth.
- **Gender** – check the appropriate gender.
- **Employee SSN** – the employee's Social Security Number (SSN).
- **Occupation Description** – identify employee's primary occupation at the time of accident

Claim Information:

- **Time of Injury** – the time when the injury/illness occurred.
- **Date Employer Had Knowledge of the Injury** – the date the employer had knowledge of the injury/illness.
- **Employment Status** – the applicable employment status for the employee (i.e. full time, part time, seasonal, volunteer, etc.).
- **Date Employer Had Knowledge of Date of Disability** – the date the employer was notified or became aware of employee's work related disability/incapacity.
- **Estimated Weekly Wage** – enter the employee's average weekly gross pay before the injury/illness.
- **Number of Days Worked Per Week** – enter the number of regularly scheduled workdays per week (1-7).
- **Work Week Type -** Check which type of work week the claimant was working at the time of injury. Standard (5 Days, scheduled Monday through Friday), Fixed (Set days of the week worked but not scheduled 5 Days, Monday through Friday), or Varied (Employee had no specific set work week schedule).
- **Work Days Scheduled -** Check which days of the week correspond with the claimant's work schedule at the time of the injury. If Work Week Type of "Varied Work Week" is selected, this field may be left blank.

Employee Injury:

- **Full Wages Paid for Date of Injury** – check *Yes* or *No*.
- **Employer Paid Salary in Lieu of Compensation** – check *Yes* or *No* to indicate if the employee continued to receive pay after the illness/injury, such as sick leave or disability pay.
- **Initial Treatment** – check the initial treatment type.
- **Death Result of Injury** – check *Yes*, *No* or *Unknown* to indicate if the injury/illness resulted in death.
- **Date of Death** – indicate the date of death, if applicable.
- **Number of Dependents** – the number of dependents, *if known (for death cases only).*
- **Natures of Injury -** indicate the type of injury (i.e. Laceration, Burns, Fracture, Strain, etc.).
- **Part of Body** – indicate the part of body that was injured (i.e. left arm, right foot, head, multiple, etc.).
- **Causes of Injury -** indicate what caused the injury (i.e. Motor Vehicle, Machine, Strain or Injury by lifting, etc.).
- **Accident/Injury Description** – describe how the accident occurred and the resulting injuries.

Work Status:

- **Initial Date Last Day Worked** – the last day worked prior to lost time.
- **Return to Work Type** – check *Actual* for employee actually returned to work, or check *Released* for employee was released to work but did not do so.
- **Initial Date Disability Began** – first day of disability (lost time) after the 7 day waiting period requirement has been met. If the employee was a Volunteer Ambulance Worker or Volunteer Firefighter there is no 7 day waiting period.
- **Physical Restrictions** – check *Yes* if the employee has returned to work with restrictions; check *No* if the employee has returned to work without restrictions.
- **Initial Return to Work Date** – if the employee has returned to work, indicate the initial return to work date.
- **Return to Work Same Employer** – check *Yes* or *No*.

Accident Location and Witnesses:

- **Premises** – check appropriate location where injury occurred. *Employer*-accident occurred on employer's premises; *Lessee*-accident occurred on the premises of the lessee for which the employee was hired to work; or *Other*-accident occurred at a location other than the employer for which the employee was hired to work. Check *Employer*, if employee was a member of a Volunteer Ambulance Service or a Volunteer Fire Department and was injured while working for his/her own service/department. Check *Other,* if the employee was injured working in an official capacity for a Volunteer Ambulance Service or Volunteer Fire Department other than the one he/she was a member of.
- **Organization Name** – the name of the organization where the injury/illness occurred.
- **Street, City, State, Postal Code, County, & Country** – the address where the injury/illness occurred.
- **Location Narrative** – provide any additional description of the location (i.e. Building C, 4th Floor in Room 101).
- **Witnesses & Business Phone Number** – indicate the names and business phone numbers of any witnesses to the injury/illness.

Employer Information:

- **Name** – the name of the company or the owner's name and DBA name. If the employee was member of a Volunteer Ambulance Service or Volunteer Fire Department, the name of the Political subdivision should be entered.
- **Employer FEIN** – your Federal Employer Identification Number (FEIN). This is your Federal Tax ID number. If you do not have a FEIN, enter your Social Security Number. If the employer was a Volunteer Ambulance Service or Volunteer Fire Department, the FEIN of the Political subdivision should be entered.
- **UI Number** – enter the first 7 digits of your New York Unemployment Insurance (NY UI) Registration Number (UIER). This is the number used to report to the Department of Labor.
- **Manual Classification Code** – the New York Compensation Insurance Rating Board (NYCIRB) manual classification code, if known. This can be found on your workers' compensation insurance policy.
- **Industry Code** – the North American Industry Classification System (NAICS). If you do not know your NAICS, please describe the type or nature of business as accurately as possible (e.g., Restaurant, Construction, Retail).
- **Info/Attn** – indicate any additional pertinent contact information for the employer.
- **Mailing Address, City, State, Postal Code, & Country** – the employer's main address where you receive mail (such as a central office). Include P.O. Boxes.
- **Physical Address, City, State, Postal Code, & Country** – the physical address of the employer (if different).
- **Supervisor Name** & **Supervisor Business Phone Number** – indicate the name and phone number for the employee's direct supervisor, including area code.

Insured Information:

- **Insured Name** – the name of the insured entity. If the employee was a member of a Volunteer Ambulance Service or a Volunteer Fire Department, the name of the ambulance service or fire department should be entered.
- **Insured FEIN** – the Insured's Federal Employer Identification Number (FEIN). This is your Federal Tax ID number. If you do not have a FEIN, enter your Social Security Number. If the insured is a Volunteer Ambulance Service or Volunteer Fire Department the FEIN of the ambulance service or fire department should be entered.
- **Insured Location ID** – indicate the Insured Location ID, if any (i.e. Store 202, Jobsite 51, etc.).
- **Insured Type** – check the insurance arrangement: *Insured*, *Self-Insured*, or *Uninsured*.
- **Policy Number ID** – your Workers' Compensation Insurance Policy Number.
- **Policy Effective** & **Expiration Date** – the policy effective and expiration dates.

New York State of Opportunity. Workers' Compensation Board

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.

Three ways to file a C-3 or C-3.3
Visit www.WCB.NY.Gov and click Workers to complete the form.
Call (877) 632-4996. A Board employee will complete the form with you.
Complete the enclosed paper forms and mail them to the Board.

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.)

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

New York State Workers' Compensation Board
PO BOX 5205
Binghamton, NY 13902-5205
wcb.ny.gov (877) 632-4996

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 insurer 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 insurers 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 would pay them back out of your lost wages award. To get a DB-450 form, visit www.wcb.ny.gov and click Workers; visit a Board office; or call (877) 632-4996.

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, including Disability Benefits	(877)632-4996	General_Information@WCB.NY.Gov www.WCB.NY.Gov
NYS Bar Association Lawyer Referral and Information Service	(800)342-3661	lr@nysba.org.

The New York State Workers' Compensation Board protects the rights of employees and employers by ensuring the proper delivery of benefits to those who are injured or ill, and by promoting compliance with the law. To learn more about the Board, visit www.WCB.NY.Gov

NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

Workers' Compensation Board

C-3

State of New York - Workers' Compensation Board

Employee Claim

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:____________________________________ 2. Date of Birth: ______/______/______
First MI Last

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 N o

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: /______/

D. YOUR INJURY OR ILLNESS *continued*

First MI Last

_ _ _ _ _ _

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: _______

0. 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: _____/_____/_____

0. 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

2. Were you treated on site? Yes No

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: (____)

0. 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:**

5. Was the previous injury/illness work related? 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:____

If yes, were you working for the same employer that you work for now? Yes No Phone Number: (__)

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.

Signature of Attorney/Representative (if any): ____ Date:
Print Name: Title: / /

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

Workers' Compensation Board

Limited Release of Health Information

(HIPAA)

State of New York - Workers' Compensation Board

C-3.3

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.

Divulgación limitada de información sobre la salud

(HIPAA)

O-3.3

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)

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 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

Workers' Compensation Temporary Prescription ID Card

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved workers' compensation prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at 1-866-590-5882.

Atencion Trabajador Lesionado:

Este form ulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).

Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 1-866-590-5882.

To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard claim limitations include quantity exceeding 150 pills or a day supply exceeding 14 days. This form is valid for up to 30 days from DOI. Limitations may vary. For assistance, call Express Scripts at 1-866-590-5882.

Pharmacy Processing Steps

Step 1: Enter bin number 003858

Step 2: Enter processor control A4

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

Group #: GJC6200

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

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
Dom inicks

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
Pharmaceutical
s 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
Wal-Mart
Wegmans
Weis
Winn Dixie

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