Need to file a Workers' Compensation claim?

We make the process easy and stress free.

At Great American, we understand that filing a claim can be stressful. That's why we give you multiple ways to report your claim.

Before reporting your claim, please have ready:

- Your policy number
- Complete and accurate information regarding the claim.

Report Online

To use the app, you will first need to register on the Great American Insured Portal

https://insuredportal.gaig.com

1. **Click the Request Access link**
2. **Complete the Policyholder Registration form**
3. **Confirm the Insured Portal system generated "Identity Verification" email**

Preregistration Required

Call our reporting center

877-836-1555

We support employers' return to work plans, and make every effort to assist you with yours. Please report a claim as soon as you are aware of it. We are available 24 hours a day, seven days a week!

Thank you for choosing Great American Insurance Group!

GREAT AMERICAN INSURANCE GROUP

Accident Information:

- Loss date and time of injury
- Date injury/occurrence reported to employer
- Time the accident was reported
- Who was the claim reported to?
- Supervisor name
- City, state, county where accident occurred
- Employer/Insured name, phone number
- What was employee doing at the time of the accident?
- Last date employee worked
- First full work day lost as a result of this injury
- Did the employee receive wage continuation (pay while off work due to injury)?
- Has employee returned to work?
- Date returned
- Was there a witness to the accident?
- Name, address and phone number of witness(es)

Employee Information:

- Name, physical home address, county, and home phone
- Date of birth, Social Security number, gender, marital status
- Regular occupation
- Department where employee regularly works
- State in which the employee was hired
- Name, address, phone number of contact person

Medical Provider Information:

- Name of clinic/doctor's office where employee was treated
- Name of treating physician, address, phone
- Name, address and phone number of hospital where employee was treated following injury

After you report a claim, the Claim Reporting Center:

- Assigns your claim to an Alternative Markets Claim professional who will contact you and your employee to acknowledge the claim and initiate the process.
- Provides you with a copy of the First Report of Injury.
- Sends this report directly to the state either by mail or electronic submission, based on your state's requirements.

EMPLOYER'S REPORT OF WORK-RELATED INJURY/ILLNESS C-2

State of New York - Workers' Compensation Board

If one of your employees has a work-related injury or illness, you must complete and file this form **within 10 days** of the injury/illness or be subject to a penalty. For additional information on filing this form please refer to Workers' Compensation Law Section 110 at the end of this form. Type or print neatly.

WCB Case Number (if you know it): _____ Date of Injury/illness: ____/____/____

Carrier Case Number (if you know it): _____ Date of this Report: ____/____/____

A. EMPLOYER INFORMATION

1. Employer: _____ 2. Employer FEIN: _____

3. Mailing Address: _____

4. Location Address (if different): _____

5. Phone Number: (____)_____ 6. Nature of Business or Industry Code: _____

7. OSHA Case Number (if known): _____ 8. NY UI Employer Reg Number: _____

B. INSURANCE CARRIER / SELF-INSURED EMPLOYER

If individually self-insured, enter your Board W Number and skip to Section C.

1.Board W Number: W _____ 2. Carrier/Group Name: _____

3. Policy Number: _____ Policy Period: From: ____/____/____ To: ____/____/____

4. If Carrier Unknown, Insurance Agent Name: _____ 5. Phone Number: (____)_____

C. EMPLOYEE'S PERSONAL INFORMATION

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

3. Mailing Address: _____

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

D. EMPLOYEE'S INJURY OR ILLNESS

1. Time of day employee began work on date of injury: _____ ☐ AM ☐ PM 2. Time of injury: _____ ☐ AM ☐ PM

3. Has the employee given you notice of injury/illness? ☐ Yes ☐ No

If yes, notice was given to: _____ ☐ orally ☐ in writing Date notice provided: ____/____/____

If available, attach a copy of the employee's written notice and medical notes, and the employer's incident report.

4. Have you given the employee a Claimant Information Packet? ☐ Yes ☐ No If yes, give date: ____/____/____

5. Where did the injury/illness happen (e.g., 1 Main St., Pottersville, at the front door): _____

_____

6. Was this location where the employee normally worked? ☐ Yes ☐ No If no, why was the employee there? _____

_____

7. Employee's supervisor: _____ 8. Did supervisor see injury happen? ☐ Yes ☐ No ☐ Unknown

9. Did anyone else see the injury happen? ☐ Yes ☐ No ☐ Unknown If yes, give name(s): _____

_____

10. What was the employee doing when he/she was injured or became ill? (e.g., unloading a truck, stocking a shelf, typing annual report)

_____

_____

EMPLOYEE'S NAME: _____ DATE OF INJURY/ILLNESS: ____/____/____
First MI Last

D. EMPLOYEE'S INJURY OR ILLNESS *continued*

11. How did the injury/illness occur? (e.g., the employee tripped over a pipe and fell on the floor) _____

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

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

14. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No

If yes, ☐ employee's vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): _____

If employer's vehicle was involved, give name and address of your motor vehicle insurance carrier: _____

15. Did the injury/illness result in the employee's death? ☐ Yes ☐ No If yes, what was the date of death? ____/____/____

Name and address of the nearest relative: _____

E. MEDICAL TREATMENT

1. What was the date of the employee's first treatment? ____/____/____ ☐ None received ☐ Unknown

2. Where did the employee receive first medical treatment for this injury/illness? ☐ On site ☐ Doctor's office ☐ Emergency Room ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours ☐ Unknown

Who treated the employee and where? _____

3. Is the employee still being treated for this injury/illness? ☐ Yes ☐ No ☐ Unknown If yes, name and address of treating doctor(s):

4. To your knowledge, did the employee have another work-related injury to the same body part or a similar illness while working for you?

☐ Yes ☐ No If yes, name the doctor(s) who treated the previous injuries/illnesses (if known): _____

F. RETURN TO WORK

1. Did the employee stop work because of his/her injury/illness? ☐ Yes ☐ No If yes, on what date? ____/____/____

2. Has the employee returned to work? ☐ Yes ☐ No

If yes, on what date? ____/____/____ ☐ regular duty ☐ limited duty

3. If the employee has returned to limited duty, what are his/her average gross earnings per week? _____

EMPLOYEE'S NAME: _____ DATE OF INJURY/ILLNESS: ____/____/____
First MI Last

G. EMPLOYEE'S WORK INFORMATION on the date of the injury or illness

1. Date the employee was hired: ____/____/____
2. What was the employee's job title? _____
3. What types of activities did the employee normally perform at work? (Attach job description if available.) _____

_____

_____

H. EMPLOYEE'S PAYROLL INFORMATION on the date of the injury or illness

1. Employee's gross pay in an average week was: $ _____
2. Did the employee receive lodging or tips in addition to pay? ☐ Yes ☐ No If yes, describe: _____

_____

3. Employee's job was (check one): ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: _____
4. Which days of the week did the employee usually work? ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat. ☐ Sun.
5. Was the employee paid for a full day on the day of the injury/illness? ☐ Yes ☐ No
6. Did you continue to pay the employee after the injury/illness (e.g., sick leave, vacation, disability, regular salary)? ☐ Yes ☐ No

I. ADDITIONAL INFORMATION

_____

_____

_____

_____

_____

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: (____)_____

If prepared by a Third Party on Behalf of the Employer:

Signature of Person Preparing Form: _____ Date: ____/____/____

Print Name: _____ Title: _____ Phone Number: (____)_____

Company Name and Address: _____

Name & Phone Number of Person Who Provided Information Necessary to Prepare This Form: _____

Reports should be filed by sending directly to the appropriate WCB district office (DO) at the address below with a copy sent to the insurance carrier:

Albany DO - 100 Broadway-Menands, Albany NY 12241 866-750-5157 (for accidents in the following counties: Albany, Clinton, Columbia, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Ulster, Warren, Washington)
Binghamton DO - State Office Building, 44 Hawley Street, Binghamton NY13901 866-802-3604 (for accidents in the following counties: Broome, Chemung, Chenango, Cortland, Delaware, Otsego, Schuyler, Sullivan, Tioga, Tompkins)
Buffalo DO - 369 Franklin Street, Buffalo NY 14202 866-211-0645 (for accidents in the following counties: Cattaraugus, Chautauqua, Erie, Niagara)
Rochester DO - 130 Main Street West, Rochester NY 14614 866-211-0644 (for accidents in the following counties: Allegany, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming, Yates)
Syracuse DO - 935 James Street, Syracuse NY 13203 866-802-3730 (for accidents in the following counties: Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego,St. Lawrence)
Downstate Centralized Mailing - PO Box 5205, Binghamton NY, 13902-5205 for all DO's in NYC 800-877-1373; in Hempstead 866-805-3630; in Hauppauge 866-681-5354; in Peekskill 866-746-0552 (for accidents in the following counties: Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Westchester)

WORKERS' COMPENSATION LAW

Section 13 Treatment and care of injured employees

(a) "The employer shall promptly provide for an injured employee such medical, surgical, optometric or other attendance or treatment, nurse and hospital service, medicine, optometric services, crutches, eye-glasses, false teeth, artificial eyes, orthotics, functional assistive and adaptive devices and apparatus for such period as the nature of injury or the process of recovery may require.****"

Section 13 Injury to employee's prosthesis

(a) "Damage to or loss of a prosthetic device shall be deemed an injury except that no disability benefits shall be payable with respect to such injury under section fifteen of this article.****"

Section 25 Effect of failure to file reports

3. (e) "If the employer or its insurance carrier fails to file a notice or report requested or required by the board or chair or otherwise required within the specified time period or within ten days if no time period is specified, the board may impose a penalty in the amount of fifty dollars.****"

Section 51 Posting of notice regarding compensation

"Every employer who has complied with section fifty of this chapter shall post and maintain in a conspicuous place or places in and about his place or places of business typewritten or printed notices in form prescribed by the chairman, stating the fact that he has complied with all the rules and regulations of the chairman and the board and that he has secured the payment of compensation to his employees and their dependents in accordance with the provisions of this chapter, but failure to post such notice as herein provided shall not in any way affect the exclusiveness of the remedy provided for by section eleven of this chapter. ****"

Section 52 Effect of failure to secure compensation

1. (a) "Failure to secure the payment of compensation shall constitute a misdemeanor, punishable by a fine of not less than five hundred nor more than two thousand five hundred dollars or imprisonment for not more than one year, or both.

(b) Where any person has previously been convicted of a failure to secure the payment of compensation within the preceding five years, upon conviction for a second violation such person shall be fined not less than one thousand nor more than five thousand dollars in addition to any other penalties including fines otherwise provided by law, and upon conviction for a third or subsequent violation such person may be fined up to seven thousand five hundred dollars in addition to any other penalties including fines otherwise provided by law.

(c) Where the employer is a corporation, the president, secretary and treasurer thereof shall be liable for failure to secure the payment of compensation under this section.****"

Section 110 Record and report of injuries by employers

1. An employer, or a third party designated by the employer, shall record any injury or illness incurred by one of its employees in the course of employment using the form prescribed by the chair for reporting injuries under subdivision two of this section. Such form, a copy of which shall be provided to the injured employee upon request, shall be maintained by the employer, or a third party designated by the employer, for at least eighteen years, and shall be subject to review by the chair at any time. Such form need not be filed with the chair unless the status of such injury or illness changes resulting in a loss of time from regular duties or in medical treatment which would require reporting in accordance with subdivision two of this section.

2. An employer, or a third party designated by the employer, shall file with the chair of the workers' compensation board and with the carrier if the employer is insured, upon a form prescribed by the chair, a report of any accident resulting in personal injury which has caused or will cause a loss of time from regular duties of one day beyond the working day or shift on which the accident occurred, or which has required or will require medical treatment beyond ordinary first aid or more than two treatments by a person rendering first aid. Such report shall state the name and nature of the business of the employer, the location of its establishment or place of work, the name, address and occupation of the injured employee, the time, nature and cause of the injury and such other information as may be required by the chair. Such report shall be filed within ten days after the occurrence of the accident. An employer shall furnish a report of an occupational disease incurred by an employee in the course of his or her employment, to the chair of the workers' compensation board, and to the carrier if the employer is insured, upon the same form. The carrier, within fourteen days of receipt of the report or accompanying the initial check forwarded to the employee, whichever is earlier, or a self-insured employer, within fourteen days of transmitting the report to the chair or accompanying the initial check forwarded to the employee, whichever is earlier, shall provide the injured employee or, in the case of death, his or her dependents with a written statement of their rights under this chapter, in a form prescribed by the chair. An employer shall file a report of any other accident resulting in personal injury incurred by its employee in the course of employment, upon the same form, whenever directed by the chair.

3. Any injury or illness which is not required to be reported in accordance with subdivision two of this section, shall not be used as a basis for determining experience modification rates, provided the employer pays in the first instance or reimburses the employer's insurer for the treatment rendered to the employee.

4. An employer who refuses or neglects to make a report or to keep records as required by this section 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 report.

5. The chair shall be authorized to promulgate regulations necessary to carry out the provisions of this section.

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

Please complete this form and send it directly to your local Workers' Compensation Board district office (DO). The addresses are listed at the bottom of page 3. Also send a copy of the form to your insurance carrier. If you need additional help in completing this form, you may contact the Workers' Compensation Board at **1-877-632-4996 or visit http://www.wcb.state.ny.us/.**

If you do not have or know your Workers' Compensation Board Case Number, please leave this field blank. It is not required to process the form. Fill out the Date of Injury/Illness, to the best of your knowledge, and the Date of this Report at the top of page 1. Remember to enter in the name of the injured employee and the date of injury/illness on the top of page 2 and page 3.

Section A - Employer Information:

Item 1: Indicate the name of the company or the owner's name and DBA name.
Item 2: Enter the employer'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.
Item 3: Enter the employer's main address where you receive mail (such as a central office). Include P.O. Boxes.
Item 4: Enter the physical address of the employer (if different).
Item 5: Enter the primary contact phone number for the employer, including area code.
Item 6: Indicate the North American Industry Classification System (NAICS) or Standard Industrial Classification (SIC) Code for your business. If you do not know your NAICS or SIC Code, please indicate the type or nature of business as accurately as possible (e.g., Restaurant, Construction, Retail).
Item 7: Enter the OSHA Case Number, if known.
Item 8: 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.

Section B - Insurance Carrier / Self-Insured Employer:

Item 1: Indicate the Carrier Code Number (**W** Number) issued by the Workers' Compensation Board. If you do not know the **W** number, contact your insurance carrier. ***If you are self-insured, only enter your Carrier Code Number (W Number) and skip to Section C.***
Item 2: Enter the name of the employer's Workers' Compensation Insurance Carrier or Group Name. If you do not know your insurance carrier, please indicate the employer's Insurance Agent Name for item 4 and the Agent's contact phone number for item 5.
Item 3: Enter your Workers' Compensation Insurance Policy Number and indicate the policy effective period for coverage at the time of the injury or illness.
Item 4: Insurance Agent Name if the carrier is unknown.
Item 5: Insurance Agent phone number, including the area code.

Section C - Employee's Personal Information:

Item 1: Indicate the injured employee's full legal name.
Item 2: Enter the employee's date of birth.
Item 3: Enter the employee's mailing address, including street number, P.O. Box (if applicable), Town or City, State, and Zip Code.
Item 4: Indicate the employee's Social Security Number (SSN).
Item 5: Enter a contact phone number for the employee, either a home phone number or a cell phone number, including the area code.
Item 6: Indicate his/her gender.

Section D - Employee's Injury or Illness:

If this is an illness or occupational disease and an exact date of illness cannot be determined, then skip items 1 and 2.
Item 1: Indicate the time of day when the employee began work on the day the injury occurred.
Item 2: Enter the time when the injury occurred.
Item 3: Check whether the employee has given notice of his/her injury or illness to the employer. If so, enter the date notice was given and if it was orally or in writing. If written notice was given, please attach a copy of the employee's notice as well as any medical notes you may have received. Also attach the [supervisor's] incident report, if available.
Item 4: Check whether you gave the employee a Claimant Information Packet and if so, when.
Item 5: 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 6: Check if this was the employee's normal work location. If it was not, explain why the employee was at this location.
Item 7: Enter the name of the employee's direct supervisor.
Item 8: Indicate whether the supervisor was a witness to the injury/illness.
Item 9: Check if anyone else witnessed the injury/illness and if so, list their name(s).

Section D - Employee's Injury or Illness (cont.):

Item 10: Describe in detail what the employee was 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 11: Describe in detail how the injury/illness occurred (e.g., the employee was lifting a heavy box off a truck). This should include all people and events involved in the injury/illness.

Item 12: Indicate fully the nature and extent of the employee's injury/illness, including all body parts injured. Be as specific as possible (e.g., lumbar gluteal muscle strain resulting from sudden straining).

Item 13: 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 14: Indicate if a licensed motor vehicle was involved in the accident. If so, check if the motor vehicle involved was the employee's, the employer's, or that of a third party and include the license plate number (if known). If the employer's vehicle was involved, fill out the automobile liability insurance carrier for the vehicle and their address.

Item 15: Check if the injury/illness resulted in the death of the employee and if so, indicate the date of death and the nearest relative of the deceased (if known).

Section E - Medical Treatment:

Item 1: If the employee did not receive medical treatment for this injury/illness, check None Received and skip to item 4. Otherwise, enter the date the employee first started treatment for this injury/illness, or check Unknown if you do not know, and complete the rest of this section.

Item 2: Check the location where initial medical treatment was administered for this injury/illness and whom was responsible for treatment/care of the employee (e.g., Physician, Nurse, EMT, etc.). Include the name of the person and the facility.

Item 3: If the employee is still receiving ongoing treatment for the same injury/illness, check Yes and indicate the name and address of the physician providing treatment; otherwise check No or Unknown.

Item 4: If the employee had a similar work-related injury to the same body part or a similar work-related illness while working for the same employer, check Yes and if known, indicate the name and address of the physician whom provided care; otherwise check No.

Section F - Return To Work:

Item 1: If the employee has stopped working as a result of the work-related injury/illness, check Yes and indicate on what date he/she stopped working.

Item 2: If the employee has since returned to work, check Yes. Also indicate on what date the employee started working again, as well as if the employee has returned to his/her Normal Duties or if the employee is on Limited or Restricted Duty. (If the employee has not returned to his/her full pre-injury or illness work duties, then the employee is on Limited Duty).

Item 3: If the employee has returned to work on Limited Duty, enter in his/her average gross earnings per week.

Section G - Employee's Work Information:

Item 1: Indicate the date the employee was hired by the employer.

Item 2: Enter the employee's current job title.

Item 3: Describe the employee's typical work activities or enter the employee's job description. If you need more space, you may attach an official job description or additional pages to completely and accurately describe the employee's work activities.

Section H - Employee's Payroll Information:

Item 1: Enter the employee's average gross weekly pay before the injury/illness.

Item 2: Check if the employee received any tips or lodging in addition to his/her regular pay and if so, describe them.

Item 3: Check the type of job the employee had.

Item 4: Check which days of the week the employee usually worked. If the employee did not work a standard work week, please explain in Section I or attach an additional page or work schedule in order to fully explain.

Item 5: Check if the employee was paid for a full day's work on the day of the injury/illness.

Item 6: Indicate if the employee continued to receive pay after the illness/injury, such as sick leave or disability pay.

Section I - Additional Information:

Enter any additional information that may be relevant to the employee's work-related injury/illness in this section. You can also use this area to further explain other items in this form, such as G-3 or H-4.

Sign Form C-2 on the last page. If the form was filled out by a third-party on behalf of the employer, that person should sign on the second signature line.

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

NOTICE OF COMPLIANCE

TO EMPLOYEES

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

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

WORKERS' COMPENSATION BOARD OFFICES

Albany, 12241 - 100 Broadway-Menands - (866) 750-5157
***Brooklyn, 11201 - 111 Livingston St. - Brooklyn - (800) 877-1373**
Binghamton, 13901 - State Office Bldg. - 44 Hawley St. - (866) 802-3604
Buffalo, 14203 - 295 Main Street, Suite 400 - (866) 211-0645
***Hauppauge, 11788 - 220 Rabro Drive - Suite 100 - (866) 681-5354**
***Hempstead, 11550 - 175 Fulton Avenue - (866) 805-3630**
***New York, 10027 - 215 W.125th St., Manhattan - (800)-877-1373**
***Peekskill, 10566 - 41 North Division St. (866) 746-0552**
***Queens, 11432 - 168-46 91st Ave., Jamaica (800) 877-1373**
Rochester, 14614 - 130 Main Street West - (866) 211-0644
Syracuse, 13203 - 935 James St. - (866) 802-3730

*** DOWNSTATE MAILING ADDRESS**
Claims-related mail for the Hauppauge, Hempstead, Peekskill and all NYC offices should be mailed to: **PO Box 5205 Binghamton, NY 13902-5205**

AVISO DE CUMPLIMIENTO

A EMPLEADOS

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

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

Robert E. Beloten

ROBERT E. BELOTEN, CHAIR/PRESIDENTE

Statewide Fax: 877-533-0337

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

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

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

Name of employer (Nombre del patrono)

.....

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

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

STATE OF NEW YORK
Andrew M. Cuomo, Governor

WORKERS' COMPENSATION BOARD
Robert E. Beloten, Chair

STATEMENT OF RIGHTS

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

YOU MAY BE ENTITLED TO WORKERS' COMPENSATION BENEFITS

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

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

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

Robert E. Beloten

ROBERT E. BELOTEN
CHAIR

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

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

C-430S (1-11) ESTE RESUMEN ESTÁ ESCRITO EN ESPAÑOL AL DORSO *www.wcb.ny.gov*

ESTADO DE NUEVA YORK
Andrew M. Cuomo, Gobernador

DECLARACION DE DERECHOS

JUNTA DE COMPENSACION OBRERA
Robert E. Beloten, Presidente

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Robert E. Beloten

ROBERT E. BELOTEN
PRESIDENTE

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

C-430S (1-11)

THIS NOTICE IS WRITTEN IN ENGLISH ON THE REVERSE SIDE.

www.wcb.ny.gov

Section 51 of the NYS Workers' Compensation Law

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

C-105.1 Reverse (9-05)

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

The undersigned employer hereby gives notice that he/she has conformed to the provisions of the Workers' Compensation Law and the rules of the Workers' Compensation Board of the State of New York, and that he/she has secured the payment of compensation to his/her employees, and the dependents of employees, engaged in employments enumerated in or brought within the provisions of said law. Such compensation has been secured for such employees in accordance with Section 50 of the Workers' Compensation law, by insuring with:
Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer:

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

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

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

C-105.1 (9-05) **THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION**