Workers Compensation Resource for Employers

Welcome,

Thank you for choosing Omaha National for your workers compensation needs. We take pride in the clients we support and will do everything we can to exceed your expectations.

This resource provides you with important information about the workers compensation laws in your state. It also provides guidance on reporting workplace injuries.

When a workplace injury occurs, it is important that you tell us right away. The sooner we know about it, the better we can manage the claim, including arranging for prompt medical care. The best way to let us know about an injury is to **call us anytime at 844-761-8400**.

Additional copies of all these documents can be printed from our website at omahanational.com.

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All documents are also available on our website at omahanational.com

Non-Compliance Notice

Please note, the use of many of the documents within this packet is required. Additional fines and enforcement actions may result from non-compliance with New York law regarding these notices.

If you have any questions regarding your responsibilities, please contact Omaha National at 844-761-8400.

POSTERS

Please post the following notices at all business locations in a common area that is visible to and frequented by employees during the workday. Examples of appropriate posting locations include a breakroom or on a wall next to a time clock. Posters must also be used in any areas used for the treatment of injured workers and the administration of first aid and on employee informational bulletin boards.

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

This document serves as the mandatory workers compensation posting notice. The poster must be printed on 8½ × 11-inch (letter size) paper. Make sure to select the appropriate insurer name from the dropdown list and enter your company name, the policy number, and the policy start and end dates on the form. Please note, the failure to post this notice may result in a $500.00 fine payable to the New York Workers' Compensation Board in addition to other penalties imposed by law.

C-105.1 – Notice to be Posted by Employers Under WCL Automotive or Horse–Drawn Vehicles:

The following employers that own or operate automotive or horse-drawn vehicles are required to use this poster:

- Employers with no minimum staff of regular employees required to report for work at an established place of business maintained by the employer
- Every employer engaged in moving household goods or furniture

When necessary, this must be posted in all vehicles owned or operated by the employer. Print this notice on a white 6 × 4-inch index card or ledger. Make sure to select the appropriate insurer name from the dropdown list and enter your company name, the policy number, and the policy start and end dates on the form. The failure to post or maintain the notice in any of the employer's vehicles is considered presumptive evidence that the employer has failed to secure the payment of compensation.

Fraud Prevention Poster:

Use this poster to reinforce the message to employees that workers compensation fraud is a serious crime and to let employees know how they can report fraud.

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

NOTICE OF COMPLIANCE

TO EMPLOYEES

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

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

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

Customer Service Line: 877-632-4996

AVISO DE CUMPLIMIENTO

A EMPLEADOS

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

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

CHAIR/PRESIDENTE
Workers' Compensation Board

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

Administrator - Omaha National Underwriters
P.O. Box 451139, Omaha, NE 68145
Phone - 844-761-8400

(Select Insurer Name)

Name of employer (Nombre del patrono)

For Insurance Carriers ONLY: Policy No.

Policy in Force from _____ *to* _____

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

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

State of New York
WORKERS' COMPENSATION BOARD

PRESCRIBED COPY
Form C-105.1

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

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

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

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

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

Administrator - Omaha National Underwriters, LLC
P.O. Box 451139, Omaha, NE 68145
Phone - 844-761-8400

(Select Insurer Name)

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

By .....

Legal Name of Insured (Employer) Signature of Employer

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

C-105.1 (9-05)

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

Section 51 of the NYS Workers' Compensation Law

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

C-105.1 Reverse (9-05)

Fake an Injury And You Can Sit Around All Day

The Workers Compensation system was created to protect injured workers. Misrepresenting an injury to collect benefits is illegal.

If you suspect workers compensation fraud or abuse report it.

844-761-8400

All information will be kept confidential.

Omaha NATIONAL

INJURY REPORT FORMS

These are documents to be completed after a workplace injury. Contact Omaha National at 844-761-8400 to report the claim.

- **C-2F – Employers' Report of Work-Related Injury/Illness:**
  New York law requires employers to keep records on all work injuries or illnesses sustained by employees. Send the completed C-2F form to Omaha National at the same time you report the claim to us. Any injuries involving medical treatment beyond first aid, more than two first aid treatments, or missed time from regular duties beyond the working day or shift on which the incident occurred are required to be reported to the State Board of Workers' Compensation. Once the claim is reported, we will submit electronic reports to the Board on your behalf.

- **C-240 – Employer's Statement of Wage Earnings:**
  This form may be used to provide information about an injured worker's wages. Send a completed copy to Omaha National at the same time you report the injury to us.

- **Incident, Supervisor, and Witness Reports:**
  When a workplace injury occurs, these forms may be used to gather information about an incident or injury. Copies should be sent to Omaha National at the same time you report the injury to us.

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 _____ **Insurer ID** _____

Name _____

Info/Attn _____

Address _____

City _____ **State** _____

Postal Code _____ **Country** _____

Claim Admin ID _____

EMPLOYEE INFORMATION

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

Last Name _____ **Suffix** _____

Mailing Address _____

City _____ **State** _____

Postal Code _____ **Country** _____

Phone Number _____ **Date of Hire** _____

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

Employee SSN _____

Occupation Description _____

CLAIM INFORMATION

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

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

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

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

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

EMPLOYEE INJURY

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

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

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

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

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

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

Accident/Injury Description (see instructions)

WORK STATUS

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

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

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

ACCIDENT LOCATION AND WITNESSES

Premises (see instructions) ☐ Employer ☐ Lessee ☐ Other

Organization Name _____

Street _____ **State** _____

City _____ **Postal Code** _____

County _____ **Country** _____

Location Narrative _____

Witnesses	Business Phone Number

EMPLOYER INFORMATION

Name _____ **Employer FEIN** _____

UI Number _____ **Manual Classification Code** _____

Industry Code _____

Info/Attn _____

Mailing Address _____

City _____ **State** _____

Postal Code _____ **Country** _____

Physical Addr _____

City _____ **State** _____

Postal Code _____ **Country** _____

Contact Name _____

Contact Business Phone Number _____

INSURED INFORMATION

Insured Name _____ **Insured FEIN** _____

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

Policy Number ID _____

Policy Effective Date _____ **Policy Expiration Date** _____

An employer or carrier, or any employee, agent, or person acting on behalf of an employer or carrier, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

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

If prepared by the employer:

Signature of Person Preparing Form _____ **Date** _____

Print Name _____

Title _____ **Phone Number** _____

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 | Workers' Compensation Board

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

Claim Information - ALL COMMUNICATION SHOULD INCLUDE THESE NUMBERS

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

Injured Worker Information

Last Name: _____ First Name: _____ MI: ___

Mailing Address: _____ Line 2: _____

City: _____ State: _____ Zip Code: _____

Job Title: _____ Social Security #: _____

Insurer Information

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

Mailing Address: _____ Line 2: _____

City: _____ State: _____ Zip Code: _____

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

Employer Information

Employer Name: _____

Mailing Address: _____ Line 2: _____

City: _____ State: _____ Zip Code: _____

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

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

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

1. Payroll information is: ☐ attached ☐ completed on page 2
2. Did the injured worker's compensation include board, rent, housing, tips and/or gratuities, in addition to gross weekly earnings? ☐ Yes ☐ No
   If Yes, what was the weekly value: _____
   Nature of the compensation:
3. Basis for the injured worker pay rate is: ☐ hourly ☐ daily ☐ weekly ☐ monthly ☐ annually
4. The injured worker works a: ☐ 5 ☐ 6 ☐ 7 ☐ Other day week. If Other, Explain: _____
5. Total days paid in the preceding 52 weeks: ____ 6. Total gross amount paid including overtime in the preceding 52 weeks: _____
7. Was there any wage adjustment made that affected the 52-week period? (If injured worker was in military service, please indicate and provide date of discharge.) ☐ Yes ☐ No
   If "Yes", explain:
8. Was the injured worker laid off during the preceding 52 weeks? ☐ Yes ☐ No
   If Yes, provide dates of layoff : _____

An employer or insurer, or any employee, agent, or person acting on behalf of an employer or insurer, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

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

Last Name: _____ First Name: _____ MI: ___

Employer Name: _____

Official Title: _____ Daytime Phone #: _____

Email Address: _____ Date of this Report: _____

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

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

Week No.	Week Ending Date	Days Paid	Gross amount paid including overtime	Week No.	Week Ending Date	Days Paid	Gross amount paid including overtime	Week No.	Week Ending Date	Days Paid	Gross amount paid including overtime
1				19				37			
2				20				38			
3				21				39			
4				22				40			
5				23				41			
6				24				42			
7				25				43			
8				26				44			
9				27				45			
10				28				46			
11				29				47			
12				30				48			
13				31				49			
14				32				50			
15				33				51			
16				34				52			
17				35				Total:		0	$ 0.00
18				36							

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

Employee of the Same Class

First Name: _____ Last Name: _____ MI: ___

Job Title: _____

Week No.	Week Ending Date	Days Paid	Gross Amount Paid including Overtime	Week No.	Week Ending Date	Days Paid	Gross Amount Paid including Overtime	Week No.	Week Ending Date	Days Paid	Gross Amount Paid including Overtime
1				19				37			
2				20				38			
3				21				39			
4				22				40			
5				23				41			
6				24				42			
7				25				43			
8				26				44			
9				27				45			
10				28				46			
11				29				47			
12				30				48			
13				31				49			
14				32				50			
15				33				51			
16				34				52			
17				35				Total:		0	$ 0.00
18				36							

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

CLAIM INFORMATION

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

INJURED WORKER INFORMATION

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

INSURER INFORMATION

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

EMPLOYER INFORMATION

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

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

PREPARED BY

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

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

Injured Worker Payroll

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

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

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

Submit by mail or electronically directly to:

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

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

Omaha NATIONAL

Incident Investigation Report

Tell us about the incident or injury right away by calling Omaha National at 844-761-8400 even if some spaces on this form are blank.

Today's Date _____

Type of Incident ☐ Death ☐ Lost Time ☐ Medical Only ☐ First Aid ☐ Property Damage ☐ Report Only / Near Miss

Date of Incident _____

Time of Incident _____ ☐ AM ☐ PM

Date Reported _____

Reported To _____

Injured Worker

Name _____

Department _____

Job Title _____

Supervisor _____

Work Schedule ☐ Mon ☐ Tue ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun

Start Shift _____ ☐ AM ☐ PM

End Shift _____ ☐ AM ☐ PM

Length in Position _____

Sex ☐ Male ☐ Female

Date of Birth _____

Date of Hire _____

Employee Type ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Temporary

Home Address _____

City, State, & Zip _____

Phone Number _____

Wages / Salary _____

Incident or Injury

Where incident occurred _____

Phase of workday ☐ During Break Period ☐ During Meal Period ☐ Working Overtime ☐ Entering or Leaving ☐ Performing Work Duties ☐ Other (Explain):

Description of incident (what the employee was doing and what happened):
Machines, materials, tools, or equipment used, handled, or involved:
Type of injury and body parts affected:

Witness(es) ☐ Yes ☐ No

Name _____ Phone Number _____

Name _____ Phone Number _____

Name _____ Phone Number _____

Medical Treatment and Work Status

First Aid Provided ☐ No ☐ Yes Describe _____

Missed Time ☐ No ☐ Yes List Day(s) _____

Returned to Work ☐ No ☐ Yes Date _____

Emergency Care ☐ No ☐ Yes

Work Status ☐ Off Work ☐ Light Duty ☐ Regular Duty

Physician Name _____ Hospital Name _____

Address _____ Address _____

City, State, & Zip _____ City, State, & Zip _____

Phone Number _____ Phone Number _____

Contributing Factors

Unsafe Workplace Conditions: (Check All That Apply)

- ☐ Inadequate Guard
- ☐ Unguarded Hazard
- ☐ Safety Device Is Defective
- ☐ Tool or Equipment Defective
- ☐ Workstation Layout Is Hazardous
- ☐ Unsafe Lighting
- ☐ Unsafe Ventilation
- ☐ Lack of Needed Personal Protective Equipment
- ☐ Lack of Appropriate Equipment / Tools
- ☐ Unsafe Clothing
- ☐ No Training or Insufficient Training
- ☐ Other: _____

Unsafe Acts by People: (Check All That Apply)

- ☐ Operating Without Permission
- ☐ Operating at Unsafe Speed
- ☐ Servicing Equipment That Has Power to It
- ☐ Making A Safety Device Inoperative
- ☐ Using Defective Equipment
- ☐ Using Equipment in An Unapproved Way
- ☐ Unsafe / Improper Lifting
- ☐ Taking an Unsafe Position or Posture
- ☐ Distraction, Teasing, Horseplay
- ☐ Failure to Wear Personal Protective Equipment
- ☐ Failure to Use the Available Equipment / Tools
- ☐ Other: _____

Describe why the unsafe conditions exist:
Describe why the unsafe acts occurred:

Preventive Measures

- ☐ Improve Enforcement
- ☐ Improve Storage / Arrangement
- ☐ Identify / Improve Personal Protective Equipment
- ☐ Task Analysis / Procedure Revision
- ☐ Use Other Materials / Supplies
- ☐ Improve Ventilation
- ☐ Improve/Change Work Method
- ☐ Improve Clean-Up Procedures
- ☐ Rotation of Employee
- ☐ Install / Revise Guards / Devices
- ☐ Improve Design/Construction
- ☐ Improve Illumination
- ☐ Reinstruction of Employees
- ☐ Other: _____
- ☐ Repair / Replace Equipment
- ☐ Eliminate Congestion
- ☐ Task Analysis to Be Completed
- ☐ Job Reassignment of Employees
- ☐ Mandatory Pre-Job Instructions
- ☐ Corrective Counseling

Fax the completed form to us at 844-761-8402 or email it to claims@omahanational.com.

Completed By _____ Date of Completion _____

Signature _____ Title _____

Supervisor's Report of Employee Incident

Manager: Tell us about the injury or incident right away by calling Omaha National at 844-761-8400 even if some spaces on this form are blank.

Injured Employee

Name _____ Employee ID _____

Job Title _____ Company Name _____

Witnesses ☐ Yes ☐ No

Name _____ Phone Number _____

Name _____ Phone Number _____

Name Phone Number

Incident

Date of Incident _____ Time of Incident _____ ☐ AM ☐ PM

Date Reported _____ Time Reported _____ ☐ AM ☐ PM

Was employee engaged in job duties at the time of incident? ☐ Yes ☐ No

Description of incident:

Machines, materials, tools, or equipment used, handled, or involved:

Type of injury and body parts affected:

Medical Treatment and Work Status

First Aid Provided ☐ No ☐ Yes Describe _____

Missed Time ☐ No ☐ Yes List Day(s) _____

Returned to Work ☐ No ☐ Yes Date _____

Work Status ☐ Off Work ☐ Light Duty ☐ Regular Duty

Emergency Care ☐ No ☐ Yes

Physician Name Hospital Name

Suggested Preventative and Corrective Measures

What actions can be taken to prevent future accidents?

Completed By _____ Date of Completion _____

Signature _____ Title _____

Fax the completed form to us at 844-761-8402 or email it to claims@omahanational.com.

Witness Statement of Injury or Incident

Manager: Tell us about the injury or incident right away by calling Omaha National at 844-761-8400 even if some spaces on this form are blank.

Witness Information

Name _____ Employee ID _____

Phone Number _____ Company Name _____

Address _____ City, State, & Zip _____

Other Witnesses ☐ Yes ☐ No

Name _____ Phone Number _____

Name _____ Phone Number _____

Name Phone Number

Incident

Date of Incident _____ Time of Incident _____ ☐ AM ☐ PM

Name of Injured Worker _____ Time Reported _____ ☐ AM ☐ PM

Location of Incident _____

Did You Observe the Incident Involving the Employee? ☐ Yes ☐ No

If no, how did you learn of the incident?

If yes, what did you see? (Use additional paper or write on the back if you need more space)

Type of injury and body parts affected:

What can be done to prevent an incident like this from happening again?

Completed By _____ Date _____

Signature _____ Title _____

Fax the completed form to us at 844-761-8402 or email it to claims@omahanational.com.

INJURED WORKER HANDOUTS

As soon as you know one of your employees may have been injured at work, please provide the following documents to the injured worker.

- **Injured Worker's First Fill Prescription Form:**
  This document contains a first fill card that an injured worker can use for a one-time fill of prescription medicines for their work injury. **It is important that you give the worker this card right away when they report an injury.** The temporary card is only valid if used within 5 days of the reported date of injury. Once the injury is reported to us, our claims staff will provide further instructions to the worker on how to get subsequent prescription fills and refills.

- **C-430S – Statement of Rights:**
  This document contains important information about benefits and claims for injured workers.

- **Claimant Information Packet: (Claimant Quick Start Guide, C-3.3 Limited Release of Health Information, C-3 – Employee Claim)**
  This packet must be provided to injured workers. This collection of documents and forms is also available in Spanish when the injured worker primarily speaks Spanish.

- **Consent and Authorization for Release of Information and Request for Medical History Forms:**
  These forms help us to obtain the information and records needed to handle a claim and to make sure that the injured worker receives the best possible medical care. Have the injured worker sign the forms and send them to Omaha National.

- **Direct Deposit Authorization Form**
  Injured workers may use this form to request benefits to be paid by direct deposit.

Injured Workers First Fill Prescription Form

Injured Worker _____ Date of Injury _____

Claim Number _____ Phone Number _____

Notice to Injured Worker and Pharmacy

This temporary First Fill card is only valid if used within 5 days of the reported date of injury. Temporary eligibility through this program allows for a one-time fill of prescription medications. For assistance processing claims please contact EHIM at (800) 311-3446.

Injured Worker Instructions

On your first pharmacy visit, please give this notice to any participating pharmacy. This will expedite the processing of your approved workers compensation prescriptions, based on the parameters established by **Omaha National**. With EHIM you do not need to complete any paperwork or claim forms. Simply present this EHIM First Fill Prescription Form to the pharmacy. You should not incur any costs or co-pays at the pharmacy and you will be allowed up to a 10 day supply of medications.

Pharmacy Instructions

For assistance processing claims please contact EHIM at **(800) 311-3446**. Please use the BIN, and Rx Group number below to process an online/electronic claim to EHIM:

Pharmacy Help Desk:
800-311-3446

BIN: **005285**
Group ID: **60011150FF**
ID #: **ONFFS** + employee 10-digit phone Number
Member: MEMBER NAME

To generate member ID: Using ONFFS as a prefix and then using the Injured Workers 10-digit phone number will be used as their member identification number when processing their First Fill Prescription.

Below is a sample listing of some of the over 72,000 Participating Pharmacies in the EHIM network. Please call **(800) 311-3446** for a participating pharmacy near you.

Costco Pharmacy	H.E.B. Pharmacies	Meijer Pharmacy	Smith's Food & Drug Centers
CVS	Hy-Vee Pharmacy	Publix Pharmacy	Target Pharmacy
Kroger Pharmacy	Safeway Pharmacy	Walmart Pharmacy	Walgreens Pharmacy
Giant Eagle Pharmacy	Wegman Pharmacy	Longs Drug Store	Ingles Pharmacy

Occupational injury/illness
STATEMENT OF RIGHTS

NEW YORK STATE | Workers' Compensation Board

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 may be entitled to lost wage benefits if your work-related injury/illness keeps you from work for more than seven days, causes you to earn lower wages, or results in a permanent disability. In volunteer firefighters' and volunteer ambulance workers' cases, compensation for lost time or loss of earning capacity may be payable from date of injury/illness.
2. You are entitled to medical treatment related to your injury/illness and should get it immediately. You can see any health care provider in an emergency. After that, you must see a NYS Workers' Compensation Board (Board) authorized provider or go to an occupational health clinic. You can search for a provider at **wcb.ny.gov**. Do not pay the health care provider directly; they will bill your employer's workers' compensation insurer. If that insurer has a pharmacy or diagnostic network, you must receive services within these networks. The insurer must tell you about its required provider networks and how to use them.
3. Your employer is liable for repairing or replacing any prosthesis (e.g., artificial members, false teeth, eyeglasses) that has been lost or damaged in the course of employment. You are also entitled to reimbursement for medication, crutches, or any equipment properly prescribed by your provider, as well as transportation and other necessary expenses for travel to and from your health care provider's office or hospital. (You should get receipts for all such expenses.)
4. Your employer is not permitted to ask you to waive your right to compensation or deduct money from your wages to pay for workers' compensation insurance premiums. Further, you cannot be fired or discriminated against because you filed a claim for benefits.
5. You are entitled to be represented by an attorney/licensed representative, but it is not required. If you do hire one, do not pay them directly. Any fee will be set by law and is deducted from your award. Attorney's fees are generally around 15% of your award and should be discussed with your attorney/licensed representative.
6. If your claim is disputed on the grounds that your injury/illness is not work-related or did not arise in the line of volunteer firefighter or ambulance worker duties, then you may be required to cover the costs of your medical treatment. You may qualify for disability benefits for non-work injuries. For information on disability benefits, contact the Board at **(877) 632-4996**.

Note: A quick return to work and an active lifestyle may help you get better faster. For help returning to work, or with family or financial problems due to your injury/illness, call the Board at **(877) 632-4996** and ask for vocational rehabilitation or social work assistance.

To file a claim:

1. Tell your employer, in writing, that you were injured or made ill due to your job, within 30 days of the accident or onset of illness.
2. Report your injury/illness to the Board as soon as possible. To do so, obtain and file an ***Employee Claim (Form C-3)***. Note: Volunteer firefighters file the ***Volunteer Firefighter's Claim for Benefits (Form VF-3)***, volunteer ambulance workers file the ***Volunteer Ambulance Worker's Claim for Benefits (Form VAW-3)***.
   IMPORTANT: If you do not notify the Board of your injury or illness within two years, you risk losing the right to benefits.
3. Tell your health care provider to send copies of medical reports concerning your claim to the Board and to your employer's insurance company at the addresses on the bottom of this form.

FOR HELP OBTAINING A CLAIM FORM OR FILLING IT OUT, OR OTHER QUESTIONS ABOUT A WORK-RELATED INJURY OR ILLNESS, PLEASE CALL (877) 632-4996. A BOARD REPRESENTATIVE WILL HELP YOU.

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:

Administrator - Omaha National Underwriters, LLC (Select Insurer Name)
P.O. Box 451139, Omaha, NE 68145
Phone - 844-761-8400

PRESCRIBED BY THE CHAIR,
WORKERS' COMPENSATION BOARD
NYS Workers' Compensation Board,
Centralized Mailing, PO Box 5205,
Binghamton, NY 13902-5205

WCB.NY.GOV

NEW YORK STATE OF OPPORTUNITY. | Workers' Compensation Board

QUICK GUIDE FOR INJURED WORKERS

You were injured at work. What now?

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

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

YOUR RESPONSIBILITIES

- Notify your employer, in writing, detailing when, where and how you were injured or became ill. Do this as soon as possible within 30 days of injury or illness. Do not text it; instead send a letter, email or other document that can be saved or printed.
- Advise your health care providers that you have a work-related injury or illness and give the name of your employer's workers' compensation insurer. If you do not know the name of your employer's insurer, either ask your employer or contact the Board immediately. Your health care provider will file medical reports with the Board and with your employer or its insurer. A medical report needs to be filed with the Board for you to access your benefits.
- File an ***Employee Claim (Form C-3)*** reporting your injury or illness to the Board as soon as possible. You must notify the Board of your injury or illness within two years. If you injured the same body part before, or had a similar illness, you must also file a ***Limited Release of Health Information (Form C-3.3)***.
  Citizenship and immigration status are not factors in workers' compensation.

How to file a claim
Quickest method: Visit **wcb.ny.gov** and select "File a Claim."
For questions about filing a ***Form C-3***, or to receive a copy of the form, please call **(877) 632-4996**. A Board representative will help you.

MEDICAL AND TRAVEL EXPENSES

Medical care to treat your work-related injury or illness is a workers' compensation benefit that is provided at no cost to you. Medical bills for your injury or illness are paid directly by your employer's workers' compensation insurer to your health care provider. If your case is disputed by the insurer, the health care providers will be paid if the Board decides your case in your favor. However, if the Board decides against you, or if you don't pursue a case, you will have to pay the health care provider or hospital (or submit the bill(s) to your own health insurer).

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

Generally, you can choose any health care provider authorized by the Board. You can search for an authorized health care provider in your area using the "Health Care Provider Search" feature at **wcb.ny.gov**. You can also use occupational health clinics. However, if your employer's workers' compensation insurer has a Preferred Provider Organization (PPO) to provide care for workers' compensation injuries, you must get your first treatment from the PPO network. If that insurer also has a pharmacy or diagnostic network, you must receive services within these networks. The insurer must tell you about its required provider networks and how to use them. However, in an emergency, you can see any provider.

BENEFITS FOR LOST WAGES

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

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

After you have healed from your injury or illness and when no further medical improvement is expected (typically one year after the date of accident/illness or surgery, if surgery was performed), you can ask your doctor to evaluate whether your accident/illness has resulted in a permanent injury/condition. To learn more about this benefit, please visit **wcb.ny.gov**, click on the "Workers" section, then select "Disability Classifications."

You may hire an attorney or licensed representative for help with your claim, but it isn't required. You or your family should not directly pay your attorney or licensed representative. Their fees are approved by the Board and deducted from your lost wage award.

If your case is disputed, you may receive disability benefits while the case is pending review by the Board. To get a ***Notice and Proof of Claim for Disability Benefits (Form DB-450)***, visit **wcb.ny.gov**; call the Board for assistance; or visit a Board office. If the case is resolved in your favor, the disability benefits will be deducted from your lost wages award.

WHAT'S NEXT?

The workers' compensation insurer will contact you. If your claim is accepted, your health care providers will be paid, and lost wage benefits begin. If your case needs a hearing, the Board will contact you. There are online resources available to make the hearing process easier:

- **eCase:** You can upload and view case-related documents online with the Board's eCase system, which is used to process claims for injured workers. You must register for eCase at **wcb.ny.gov**.
- **Virtual Hearings:** You have the option of attending hearings without having to travel to a Board office by using virtual hearings. Learn more about virtual hearings, and the Board's free app, at **wcb.ny.gov/virtual-hearings**.

HELP IS AVAILABLE

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

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

Important Contact Information

Workers' Compensation Board	(877) 632-4996	claims@wcb.ny.gov
		wcb.ny.gov

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

NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

WCB-Claimant-QuickGuide-v1 (1-21)

NEW YORK STATE | 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.

NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

Employee Claim

C-3

State of New York - Workers' Compensation Board

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

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Employee)

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

3. Mailing address: _____ (Number and Street/PO Box/Apartment No. / City / State / Zip Code)

4. Social Security Number: ____-____-____ 5. Phone Number: (____)_____ 6. Gender: ☐ M ☐ F ☐ X

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

B. YOUR EMPLOYER(S)

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

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

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

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

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

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

1. What was your job title or description? _____

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

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

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

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

D. YOUR INJURY OR ILLNESS

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

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

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

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

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

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

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

D. YOUR INJURY OR ILLNESS *continued*

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

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

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

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

E. RETURN TO WORK

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

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

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

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

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

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

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

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

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

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

Print Name: _____ Title: _____

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

Instructions for Completing Employee Claim (Form C-3)

Please complete this form and send it to the Workers' Compensation Board centralized mailing address listed at the end of these instructions. If you need additional help completing this form, contact the Workers' Compensation Board at **1-877-632-4996.** You may also fill this form out online at **wcb.ny.gov**. If you do not have or know your Workers' Compensation Board Case Number, please leave this field blank. It is not required to process your claim. Remember to enter your name and the date of your injury/illness on the top of page two.

Section A - Your Information (Employee):

In Section A, enter your name, address and other requested information.
Note on Item 7: Board hearings are conducted in English. If you need a translator, select **Yes** and indicate the language needed.

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

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

Section B - Your Employer(s):

In Section B, enter the name, address, phone number and other information of the employer you were working for at the time of the injury/illness.
Note: Your employer is the company or agency that issues your paycheck. If you are a contractor at a work site or office, the staffing agency or vendor who hired you is your employer, not the work site or office where you report to work.

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

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

Section D - Your Injury or Illness:

In Section D, enter your injury or illness information.
Item 1: Enter the date you were injured or the first date you noticed you became ill.
If this is an illness or occupational disease, skip item 2. The date you were injured must be in month/day/year format. The year should be written as four digits, e.g., 2015.
Item 2: Enter the time when the injury occurred. Check whether it was AM or PM.
Item 3: Indicate the location where the injury/illness occurred, including the address of the building and the physical location in the building where the injury/illness happened.
Item 4: Check whether this was your normal work location. If it was not, explain why you were at this location.
Item 5: Describe in detail what you were doing at the time of the injury/illness (e.g., unloading boxes from a truck by hand). This explains the events leading up to the injury.
Item 6: Describe in detail how the injury/illness occurred (e.g., I was lifting a heavy box off a truck). This should include all people and events involved in the injury/illness.
Item 7: Indicate fully the nature and extent of your injury/illness, including all body parts injured. Be as specific as possible (e.g., I strained my back trying to lift a heavy box. It hurts to bend over or hold even lighter objects now).
Item 8: Indicate if some object was involved in the accident **other than** a licensed motor vehicle. Other objects may include a tool (e.g., hammer), a chemical (e.g., acid), machinery (e.g., forklift or drill press), etc.
Item 9: Indicate if a licensed motor vehicle was involved in the accident. If so, check if the motor vehicle involved was yours, your employer's, or a third party's. Include the license plate number (if known). If your vehicle was involved, fill out the name and address of your automobile liability insurance carrier.
Item 10: Check if you gave your employer or supervisor notice of your injury or illness. If so, indicate who you gave notice to as well as if it was orally or in writing. Include the date you gave notice.
Item 11: Check if anyone else saw the injury happen. If anyone did see it, include their name(s).

Section E - Return to Work:

Item 1: If you stopped working as a result of your work-related injury/illness, check Yes and indicate the date you stopped working. If you have not stopped working, check No and skip to the next section.
Item 2: If you have since returned to work, check Yes. Also indicate on what date you started working again, as well as if you have returned to your Normal Duties or if you are on Limited or Restricted Duty. (If you have not returned to your full pre-injury or illness work duties, then you are on Limited Duty.)
Item 3: If you have returned to work, indicate who you are working for now.
Item 4: Enter your gross pay (before tax pay) per pay period for the job you are working at now. Indicate how often you are receiving a paycheck (weekly, bi-weekly, etc.).

Section F - Medical Treatment for This Injury or Illness:

Item 1: If you did not receive medical treatment for this injury/illness, check None Received and skip to item 5. Otherwise, enter the date you first received treatment for this injury/illness and complete the rest of this section.
Item 2: Check if you were first treated on the job for this injury or illness.
Item 3: Check the location where you first received off site medical treatment for your injury or illness. Include the name and address of the facility as well as the phone number (including area code).
Item 4: If you are still receiving ongoing treatment for the same injury or illness, check Yes and indicate the name and address of the doctor(s) providing treatment as well as the phone number (including area code); otherwise, check No.
Item 5: If you already had an injury to the same body part or a similar illness, check Yes and indicate if you were treated by a doctor for this injury or illness. If you were treated by a doctor, indicate the name(s) and address(es) of the doctor(s) whom provided care and **complete and file Form C-3.3 together with this form.**
Item 6: If you had a previous injury or illness, check if your previous injury or illness was work-related. If Yes, check if the injury or illness happened while working for your current employer.

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

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

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

Your Rights:

1. Generally, you are entitled to be treated by a doctor of your choice, provided they are 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, their 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

Consent and Authorization for Release of Information

Injured Worker	_____	Provider Name	_____
Employer	_____	Address	_____
Date of Birth	_____	City and State	_____
Date of Injury	_____	Phone Number	_____

The above entity, facility, or medical practitioner is authorized to release my information as provided below:

I authorize Omaha National, their staff, representatives, or bearer, to review, inspect, copy, and/or photograph all records or files, including but not limited to the following:

- **Medical Records:** All medical charts, files, records, and reports, including office and hospital records, laboratory results, diagnostic reports and films, psychiatric records, medical correspondences, doctor's and nurse's notes, and medical histories relevant to my workers compensation claim. I also give my permission for Omaha National to contact the attending physicians involved in the treatment of all related conditions.

  Please note, 45 CFR 164.512(l) states, "A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault."

- **Employment Records:** All employment and human resource information, including hiring and employment records, payroll and income statements, documentation related to this or any other relevant injury, and any other information pertinent to providing benefits and services necessary for the completion of this claim.

This consent and authorization is effective immediately. A photocopy of the authorization may be accepted in place of the original. This authorization is subject to revocation by the undersigned at any time, except to the extent that action has already been taken in reliance on this consent, and it terminates on conclusion of the workers compensation claim without express revocation. A request for revocation may be submitted in writing to Omaha National Underwriters at P.O. Box 451139, Omaha, NE 68145.

This information is required for the following:

- For the investigation, review, analysis, and discovery of a workers compensation claim and to determine the causation, nature, and extent of any possible pre-existing, concurrent, or aggravating medical conditions with potential medical, legal, or factual implications for the work-related injury or injuries.
- To provide important medical information to the treating physician, consultant, or evaluator so the injured worker may receive the best possible medical care and advice.
- To facilitate recovery from any third party responsible for the injury.
- To ensure that the injured work is accurately compensated for any amount of lost wages, time, or resources while undergoing evaluation, treatment, and recovery for the injury.
- To develop an appropriate plan of action for resolving the claim.

I have read this authorization and fully understand its entire contents. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations. I have asked questions about anything that was not clear to me and I am satisfied with the answers I have received. I understand that I have a right to receive a copy of this authorization upon my request.

Signature _____

Printed Name _____ Date _____

Fax the completed form to us at 844-761-8402 or email it to claims@omahanational.com.

Omaha NATIONAL

Request for Medical History

Injured Worker _____ Date of Injury _____

Employer _____ Current Date _____

Provide your medical history to ensure that you receive the proper medical care for your work injury.

Family Doctor / Primary Health Care Provider and Other Treating Doctors			
Name	Address	Phone	Condition Being Treated

Medications / Prescriptions			
Name	Description/Purpose	Dosage	Prescribing Doctor

Hospitalizations and Surgical Procedures			
Date(s)	Diagnosis/Treatment/Procedure	Doctor	Hospital

Please check to indicate if you have ever had any of the following conditions:

- ☐ Arthritis
- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Thyroid disorder
- ☐ Cancer – type: _____
- ☐ Stroke
- ☐ Stomach or peptic ulcer
- ☐ Kidney stones
- ☐ Kidney disease
- ☐ Epilepsy (seizures)
- ☐ Heart problems
- ☐ Back problems
- ☐ Knee, hip, or foot problems
- ☐ Shoulder, elbow, or wrist problems
- ☐ Carpal tunnel
- ☐ Blood clotting disorders
- ☐ Psychological condition

Fax the completed form to us at 844-761-8402 or email it to claims@omahanational.com.

Signature _____ Date _____

Direct Deposit (ACH) Authorization Form

Injured Worker _____ Claim Number _____

Employer _____ Date of Injury _____

Instructions: Complete this form in its entirety, attach a copy of a voided check(s) or letter from bank confirming the account details and make a copy for your records. Direct deposit is only available if your financial institution is part of the New York State Automated Clearinghouse. In addition, your name MUST appear on the account.

Claimant's Rights to Direct Deposit:

- This form is optional, but you have the right to receive your workers' compensation indemnity benefits or death benefits in the form of direct deposit. You also have the right to receive your workers' compensation indemnity benefits or death benefits by paper check in the mail.
- You have the right to cancel the direct deposit at any time by checking the appropriate box on this form and forwarding the completed form to the claim administrator responsible for the workers' compensation claim. The request will be implemented within forty-five days of receipt of notice, and thereafter payment of benefits will be sent by paper check.
- Beginning July 1, 2021, you have the right to have such payments deposited into at least two bank accounts at your request, either as a percentage of the total benefit or a fixed dollar amount for each deposit. The claim administrator may require a minimum amount of up to $20 into each bank account.

Authorizations & Understandings:

- I authorize the claim administrator to directly deposit my workers' compensation indemnity benefits or death benefits into the specified bank account(s).
- I authorize the claim administrator to debit the account in order to recover any credits deposited in error. The claim administrator may recover credits deposited in error by any lawful means. IMPORTANT: This consent does not authorize the claim administrator to recover alleged over payments of established and awarded benefits.
- I understand that any change in my employment status may affect my right to receive benefits.
- I understand that any false statement or failure to disclose a material fact in order to obtain or increase my benefits may result in criminal prosecution, disqualification from benefits, and repayment of any funds deposited to my account.
- I understand that the failure to notify the insurance carrier, self-insured employer, or third-party administrator (TPA) (claim administrator) any change in financial institution or account may delay receipt of my benefits or settlement proceeds.
- I understand that in order to change or cancel the direct deposit for my workers' compensation indemnity benefits or death benefits, I need to submit this form to the claim administrator.
- I understand that I have an obligation to immediately notify the claim administrator if I am no longer entitled to such payments, or of changes in circumstances which affect my entitlement to such payment.
- I understand that the claim administrator may require me to certify annually that I continue to elect the receipt of such benefits by direct deposit, and that if I fail to do so, the claim administrator may discontinue direct deposit and thereafter provide benefits by paper check.

Type ☐ New Enrollment ☐ Change ☐ Cancel

Depositor/Claimant's Name _____ WCB Claim Number _____

Phone Number _____ Email Address _____

Address _____

Type of Account ☐ Checking ☐ Savings Name of Bank / Financial Institution _____

Bank Routing Number (ABA#) _____ Bank Account Number (EFT Format) _____

Bank City, State _____ $ or % of Deposit _____

Optional 2nd Account

Type of Account ☐ Checking ☐ Savings Name of Bank / Financial Institution _____

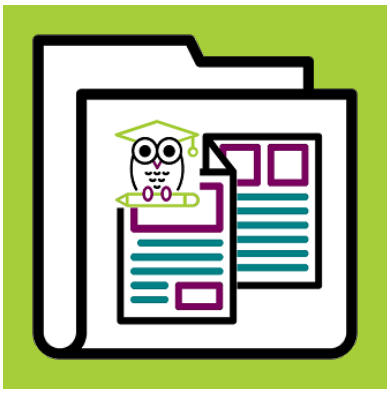
Bank Routing Number (ABA#) _____ Bank Account Number (EFT Format): _____

Bank City, State: _____ $ or % of Deposit _____

DEPOSITOR/CLAIMANT/JOINT ACCOUNT HOLDER CERTIFICATION: I certify that I am entitled to receive the underlying compensation payments or death benefits and circumstances entitling me to benefits or death benefits have not changed. I understand that the claim administrator may request an annual certification of continued entitlement to such payments or benefits and that such certification must be provided within sixty days in order to continue payments by direct deposit.

Depositor/Claimant Signature _____ Date _____

Joint Account Holder Signature _____ Date _____



INFORMATIONAL DOCUMENTS

Keep these documents for your future reference.

- **Omaha National Contact Information:**
  This document contains the contact information for our Claims department.

- **Reduce Your Workers Compensation Costs:**
  Tips for lowering your company's workers compensation costs.

- **Your Responsibilities as an Employer: Reporting Injury and Illness:**
  The New York Workers' Compensation Board created this document as a brief guide on employer reporting requirements.

Contact Information

Claims:

Phone	**844-761-8400**
Fax	844-761-8402
Online	omahanational.com
Email	claims@omahanational.com
Mail	P.O. Box 451139, Omaha, NE 68145

Reduce Your Workers Compensation Costs

Injury Prevention and Safety Training

According to the Occupational Safety and Health Administration (OSHA), businesses spend $170 billion a year on occupational injuries and illnesses. Companies that establish safety programs to prevent injuries can reduce those costs by 20 to 40 percent. Safe workplaces also improve employee morale and can lead to increased productivity and improved service. Omaha National has resources to help you develop a program focused on the hazards specific to your business.

Report Injuries Immediately

The single most important thing you can do to reduce your claim costs is to report injuries to us immediately. The best way to do that is to call us anytime an injury occurs, 24 hours a day, seven days a week. The sooner we learn of an injury the better we can investigate the claim and arrange for appropriate medical care. It also helps prevent financial penalties from state regulatory agencies.

Ways to report an injury:

- **Phone: 844-761-8400**
- Fax: 844-761-8402
- Online: omahanational.com
- Email: claims@omahanational.com
- Mail: P.O. Box 451139, Omaha, NE 68145

High-Quality Medical Care

Ensuring that injured workers receive quality medical treatment is important. The right doctor can have a big impact on the successful recovery of an injured employee and on the cost of a claim. In certain states, Omaha National has established custom medical networks and panels including the right specialists to treat each injury in a safe, cost-effective manner, with a focus on early return-to-work.

Establish a Return-To-Work Program

Another way to reduce claim costs is to implement a return-to-work program that helps your injured worker get back to work quickly and safely while recovering from the injury. The program does not need to be complicated: the most important thing is to work with our claims adjuster to coordinate a successful return to work. The program can also include accommodations such as altered schedules, transitional work duties, or reassignment to an alternate position. Omaha National can provide helpful suggestions and advice to administer a return-to-work program.

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 any work-related injury or illness. The Board must 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**.

GENERAL FORMS

Use these forms as needed and send to Omaha National. Forms may be faxed to 844-761-8402.

- **Request for Subrogation Waiver:**
  Use this form to request to have a subrogation waiver added to your policy.

- **Form ERM-14 - Confidential Request for Ownership Information:**
  Changes in ownership may impact your policy and the factors used to determine your premium. These changes must be reported to us right away.

- **Company Contacts Verification:**
  This form is used to provide your company contacts for questions and issues pertaining to your payroll and/or workers compensation policy.

Omaha
NATIONAL

Request for Subrogation Waiver

Please complete the information below to request the addition of a subrogation waiver to your policy. A subrogation waiver may only be obtained if your company performs work under a written contract that requires such a waiver. You must maintain payroll records accurately segregating the payroll of your employees engaged in the specified job(s).

Please contact your Account Manager at 844-761-8400 if you have any questions.

General Information

Policyholder Name ______________________________
FEIN ______________________________
Policy Number ______________________________
Waiver Type Requested ☐ Blanket Waiver ☐ Specific Waiver (if applicable, please complete fields below)

Job Information for Specific Waiver

Job Effective Date(s) From ____________ To ____________
Job Name or Number ______________________________
Person or Organization ______________________________
Brief Description of Job ______________________________
Complete Address ______________________________
Employee Class Code ________ Employee Class Code ________ Employee Class Code ________
Payroll Amount ________ Payroll Amount ________ Payroll Amount ________

Job Information for Specific Waiver

Job Effective Date(s) From ____________ To ____________
Job Name or Number ______________________________
Person or Organization ______________________________
Brief Description of Job ______________________________
Complete Address ______________________________
Employee Class Code ________ Employee Class Code ________ Employee Class Code ________
Payroll Amount ________ Payroll Amount ________ Payroll Amount ________

Job Information for Specific Waiver

Job Effective Date(s) From ____________ To ____________
Job Name or Number ______________________________
Person or Organization ______________________________
Brief Description of Job ______________________________
Complete Address ______________________________
Employee Class Code ________ Employee Class Code ________ Employee Class Code ________
Payroll Amount ________ Payroll Amount ________ Payroll Amount ________

Job Information for Specific Waiver

Job Effective Date(s) From ____________ To ____________
Job Name or Number ______________________________
Person or Organization ______________________________
Brief Description of Job ______________________________
Complete Address ______________________________
Employee Class Code ________ Employee Class Code ________ Employee Class Code ________
Payroll Amount ________ Payroll Amount ________ Payroll Amount ________

Job Information for Specific Waiver

Job Effective Date(s) From ____________ To ____________
Job Name or Number ______________________________
Person or Organization ______________________________
Brief Description of Job ______________________________
Complete Address ______________________________
Employee Class Code ________ Employee Class Code ________ Employee Class Code ________
Payroll Amount ________ Payroll Amount ________ Payroll Amount ________

Submitter Information

Completed by ______________________ Date ______________________
Title ______________________ Signature ______________________

Fax the completed form to us at 844-761-8402 or email it to customerrelations@omahanational.com.

Last Revised – 9/27/2021

RATING BOARD COMBINABLE ID: _____

RATING BOARD ANALYST: _____

ERM-14 FORM—CONFIDENTIAL REQUEST FOR OWNERSHIP INFORMATION

All items must be answered completely or the form may be returned.

The following confidential ownership statements will be used only in establishing premiums for your insurance coverage's. Your workers compensation policy requires that you report ownership changes, and other changes as detailed below, to your insurance carrier in writing within 90 days of the change. If you have questions, contact your agent, insurance carrier, or the Rating Board. Once completed, this form must be submitted to the Underwriting Department of the Rating Board by you, your insurance carrier(s), or your agent(s). If this form does not provide the means to explain the transaction, enter as much information on the form as possible and supplement the form with a narrative on the employer's letterhead, signed by an owner, partner, or executive officer.

Section A—Transaction and Entity Information

Check all that apply	**Type of Transaction** **Columns A, B, and C referenced below are found in Section B.**	**Effective Date** **Enter effective date of transaction**	**Report Date** **Enter date reported in writing to your insurance provider**
	Name and/or legal entity change—Complete column A for former entity and column B for newly named entity. Complete Type of Entity portion for each entity to reflect such change.		
	Sale, transfer or conveyance of all or a portion of an entity's ownership interest—Complete column A for ownership before the change and column B for ownership after the change.		
	Sale, transfer or conveyance of an entity's physical assets to another entity that takes over its operations—Complete column A for the former entity and column B for the acquiring entity.		
	Merger or consolidation (attach copy of agreement)— Complete columns A and B for the former entities and column C for the surviving entity.		
	Formation of a new entity that acts as, or in effect is, a successor to another entity that: (a) Has dissolved (b) Is non-operative (c) May continue to operate in a limited capacity.		
	An irrevocable trust or receiver, established either voluntarily or by court mandate—Complete column A before the change and column B after the change.		
	Determination of combinability of separate entities— Complete a separate column in Section B for each entity to be reviewed for common ownership (attach additional forms if necessary).		

ENTITY 1—Complete Column A on Page 3

Complete Name of Entity (including DBA or TA) _____

Risk ID _____ **FEIN** _____

Type of Entity (check all that apply) **Carrier** _____ **Policy #** _____ **Eff. Date** _____

☐ Sole Proprietorship	☐ Limited Partnership	☐ Temporary Labor Service	☐ School District	☐ Irrevocable Trust
☐ Partnership	☐ Limited Liability Corporation	☐ Publicly Traded	☐ For Profit	☐ Religious Organization
☐ Domestic Corporation	☐ Joint Venture	☐ State Agency	☐ Not for Profit	☐ Charitable Organization
☐ Foreign Corporation	☐ Association (including unincorporated)	☐ County Agency	☐ Non-Profit	☐ Franchise
☐ Sub-Chapter S-Corp	☐ Employee Leasing	☐ Municipality	☐ Revocable Trust	☐ ESOP

Primary Address

Street _____ City, State, Zip _____

Telephone Number _____ Fax Number _____ E-mail Address _____

Contact Name _____ Web Site _____

Mailing Address (if different than Primary Address) _____

Additional Locations(s) _____

ENTITY 2—Complete Column B on Page 3

Complete Name of Entity (including DBA or TA) _____

Risk ID _____ **FEIN** _____

Type of Entity (check all that apply) **Carrier** _____ **Policy #** _____ **Eff. Date** _____

☐ Sole Proprietorship	☐ Limited Partnership	☐ Temporary Labor Service	☐ School District	☐ Irrevocable Trust
☐ Partnership	☐ Limited Liability Corporation	☐ Publicly Traded	☐ For Profit	☐ Religious Organization
☐ Domestic Corporation	☐ Joint Venture	☐ State Agency	☐ Not for Profit	☐ Charitable Organization
☐ Foreign Corporation	☐ Association (including unincorporated)	☐ County Agency	☐ Non-Profit	☐ Franchise
☐ Sub-Chapter S-Corp	☐ Employee Leasing	☐ Municipality	☐ Revocable Trust	☐ ESOP

Primary Address

Street _____ City, State, Zip _____

Telephone Number _____ Fax Number _____ E-mail Address _____

Contact Name _____ Web Site _____

Mailing Address (if different than Primary Address) _____

Additional Locations(s) _____

ENTITY 3—Complete Column C on Page 3

Complete Name of Entity (including DBA or TA) _____

Risk ID _____ **FEIN** _____

Type of Entity (check all that apply) **Carrier** _____ **Policy #** _____ **Eff. Date** _____

☐ Sole Proprietorship	☐ Limited Partnership	☐ Temporary Labor Service	☐ School District	☐ Irrevocable Trust
☐ Partnership	☐ Limited Liability Corporation	☐ Publicly Traded	☐ For Profit	☐ Religious Organization
☐ Domestic Corporation	☐ Joint Venture	☐ State Agency	☐ Not for Profit	☐ Charitable Organization
☐ Foreign Corporation	☐ Association (including unincorporated)	☐ County Agency	☐ Non-Profit	☐ Franchise
☐ Sub-Chapter S-Corp	☐ Employee Leasing	☐ Municipality	☐ Revocable Trust	☐ ESOP

Primary Address

Street _____ City, State, Zip _____

Telephone Number _____ Fax Number _____ E-mail Address _____

Contact Name _____ Web Site _____

Mailing Address (if different than Primary Address) _____

Additional Locations(s) _____

Section B—Ownership

1. Have any of these entities operated under another name in the last four years? ☐ Yes ☐ No
2. Are any of the entities **currently** related through common majority ownership to any entity not listed on the front of the form? ☐ Yes ☐ No
3. Have any of these entities been **previously** related through common majority ownership to any other entities in the last four years?
   ☐ Yes ☐ No
4. If you answered Yes to questions 1, 2, or 3 above, provide additional information, indicating which question(s) your answer references?
   ☐ **1** ☐ **2** ☐ **3**

Name of Business	Principal Location	Carrier and Policy Number	Effective Date

5. Were the assets and/or ownership interest (all or a portion) of this entity acquired from a previously existing business? ☐ Yes ☐ No
   If yes, you must provide complete ownership information for the prior owner in column A and ownership information for the new owner in column B.
6. If this is a partial sale, transfer, or conveyance of an existing business (i.e., sale of one of more plants or locations):
   a. Explain what portion or location of the entire operation was sold, transferred, or conveyed.

   _____

   b. Was this entity insured under a separate policy from the remaining portion? ☐ Yes ☐ No
   If not, specify the entities with which it was combined:

   _____

7. Did the legal status of this entity change? ☐ Yes ☐ No
   If yes, you must complete the Type of Entity portion for each entity to reflect such change.
8. Is this transaction a result of bankruptcy? ☐ Yes ☐ No
   If yes, please indicate under which Chapter the bankruptcy was filed. _____

Corporations—List all names of owners of 5% or more of voting stock and number of shares owned. Submit shareholder proposal if transaction involved exchange of stock.

Partnerships—List each partner and appropriate share in the profits. If the entity is a limited partnership, list name(s) of each general partner(s).

Other—If no voting stock, list members of board of directors or comparable governing body.

Information	Column A	Column B	Column C
	Enter name used in Section A for Entity 1 **Entity 1**	Enter name used in Section A for Entity 2 **Entity 2**	Enter name used in Section A for Entity 3 **Entity 3** If applicable, use this column for multiple combinations or entities resulting from mergers and consolidations
Name of Entity			
Ownership See reference above to ownership information required for corporations, partnerships, and other entities.			
Total Ownership Interest or Number of Shares			

NOTE: If your business has changed significantly to result in a change to the primary (governing) classification and the process and hazard of the operation have also changed, contact your agent, insurance carrier or the Rating Board for additional information.

Section C—Additional Information

Please include any additional information you believe pertinent to the transaction detailed above that cannot be expressed due to the format of this form. If there is not enough space below, attach the information on the entity's letterhead, signed by an owner, partner, or executive officer.

Section D—Did You Remember to . . .

- Indicate the type of transaction, check all that apply, and include transaction and notification dates?
- Complete all necessary entity information? **Note:** You can use more forms if the number of entities exceeds three.
- Entity name
- Risk identification number (if you know it)
- Federal Employer Identification Number (FEIN)
- Type of entity
- Primary address, telephone, and other contact information
- Mailing address and additional locations if applicable
- Fill out the ownership table completely?
- Include the names of the entities as listed in Section A?
- Include all owners, partners, board of director members, members and/or manager of LLCs, general partners of LPs, or any other comparable governing body?
- Include percentage of ownership for each owner, partner, board of director member, member and/or manager of LLCs, general partner of LPs, or any other comparable governing body?
- Answer question 1 through 8?

Section E—Certification

This is to certify that the information contained on this form is complete and correct.
All forms will be returned if this Certification Section is incomplete.

Name of person completing form: _____

Check which entity or entities the signer represents: ☐ Entity 1 ☐ Entity 2 ☐ Entity 3 ☐ Other _____

_____	_____	_____
Signature of Owner, Partner, Member, or Executive Officer	Title	Carrier
_____	_____	_____
Print name of above signature	Date	Carrier Address

Section F—For Rating Board Use Only

Associated/automated _____

Date received _____

Date complete _____

Assessment—form complete? What is missing? _____

Ruling _____

Revisions necessary—Yes/No/NA _____

Rating Effective Date impacted—Yes/No—if Yes, which ones? _____

Risk ID impacted—list all impacted, any deactivated? Indicate deactivated #s_____

All carriers/rating organizations notified?_____

NEW YORK COMPENSATION INSURANCE RATING BOARD

INSTRUCTIONS FOR COMPLETING AN ERM-14 FORM

I. PURPOSE AND EFFECTIVE DATE OF CHANGE

a) **Combination of Separate Entities—**If two or more entities share common ownership (more than 50% common ownership in each entity) the experience must be combined for experience rating purposes and/or if two or more entities wish to be written on one policy.

Note:

1) Include the date interest was acquired in each entity.
2) If you wish to show non-combinability, list the ownership of each entity in the columns provided.

b) **Change of Ownership—**Required if there has been a change in the name of the entity, governing board, or ownership.

c) **Merger or Consolidation**

1) **Merger—**When two or more entities are merged into one surviving entity.
Note: Include the merger agreement.
2) **Consolidation—**When two or more entities are combined into an entirely new entity.
Note: Include the date the merger or consolidation occurred.

II. INFORMATION

a) **Name and Location of Entity—**Furnish both names and locations of each entity before and after the change occurred.

b) **Policy Number—**List the policy number if available.

c) **Rating ID Number—**List the rating ID number if available.

d) **List—**The type of entity for each column.

e) **FEIN Number—**List the Federal Employer Identification Number.

f) **List—**The date the change was reported in writing to the carrier.

III. OWNERSHIP INFORMATION

a) **When listing ownership for each entity, remember:**

1) List all names of owners and their individual percentage of ownership (each spouse's individual ownership must be listed).
2) If it is a partnership, list all general partners' names and their percentage of ownership.
3) If it is a corporation, list owners and their percentages of 5% or more of voting stock.
4) If an entity is other than a sole proprietor, partnership, or corporation, list all members of the governing board of each entity.
5) List the total shares of stock issued at the bottom of each column.
6) For trusts, specify if revocable or irrevocable along with the following:
   I. For revocable trusts, list the owners of the assets who make up the trust.
   II. For irrevocable trusts, list the trustees.

b) **Combination—**Enter each entity to be combined in each of the columns. List complete ownership for all entities. Include the date ownership was acquired for each entity. Use as many columns or additional sheets as necessary.

c) **Change of Name/Ownership—**In Column A, list the name of the entity and ownership before the change; in column B, list the name of the entity and ownership after the change.

d) **Merger/Consolidation—**In Columns A and B, enter the names of the entities and the ownership of each entity involved; in column B, list the name of ownership of the remaining entity.

IV. SIGNATURE

The signature of the sole proprietor, partner, or executive officer must be included on the form. Please include the title and the date the form is signed.

Company Contacts Verification

Please complete the information below to confirm your company contacts for questions and issues pertaining to your payroll and/or workers compensation policy.

Please contact your Account Manager at 844-761-8400 if you have any questions.

General Information

Policyholder Name _____
FEIN _____
Policy Number _____
Main Address _____
Phone Number _____
Fax Number _____
Company Website _____

Company Contacts for Invoice Questions/Issues

Primary Contact Name		Alternate Contact Name	
Office Phone Number		Office Phone Number	
Cell Phone Number		Cell Phone Number	
Fax Number		Fax Number	
Email Address		Email Address	

Company Contacts for Payroll Questions/Issues

☐ Check if same as above

Primary Contact Name		Alternate Contact Name	
Office Phone Number		Office Phone Number	
Cell Phone Number		Cell Phone Number	
Fax Number		Fax Number	
Email Address		Email Address	

Company Contacts for Policy Questions/Issues

☐ Check if same as above

Primary Contact Name		Alternate Contact Name	
Office Phone Number		Office Phone Number	
Cell Phone Number		Cell Phone Number	
Fax Number		Fax Number	
Email Address		Email Address	

Company Contacts for Claims Questions/Issues

☐ Check if same as above

Primary Contact Name		Alternate Contact Name	
Office Phone Number		Office Phone Number	
Cell Phone Number		Cell Phone Number	
Fax Number		Fax Number	
Email Address		Email Address	

Submitter Information

Completed by		Date	
Title		Signature	

Fax the completed form to us at 844-761-8402 or email it to customerrelations@omahanational.com.

STATE-SPECIFIC FORMS & DOCUMENTS

Use these forms as needed. Send copies of the completed forms to Omaha National.

- **C-105.32 - Notice of Election to Bring Partners, Members or Self-Employed Persons Under the Coverage of the New York State Workers' Compensation Law:**
  This form may be used by partnerships, LLPs, PLLPs, LLCs, PLLCs and sole proprietors to document an election of coverage for partners, members, or self-insured persons.

- **C-105.51 - Notice of Election to Exclude Sole Shareholder Officer or Two Executive Officers of the Corporation from Compensation Coverage:**
  Corporations may use this form to document a coverage exclusion for executive officers.

- **C-105.55 - Revocation of Election to Exclude Sole Shareholder or Two Executive Officers from Compensation Coverage**
  This form is used to reverse a prior coverage election for executive officers.

State of New York
WORKERS' COMPENSATION BOARD

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

NOTICE OF ELECTION OF A PARTNERSHIP, LIMITED LIABILITY PARTNERSHIP, PROFESSIONAL LIMITED LIABILITY PARTNERSHIP, LIMITED LIABILITY COMPANY, PROFESSIONAL LIMITED LIABILITY COMPANY OR SOLE PROPRIETORSHIP TO BRING PARTNERS, MEMBERS OR SELF-EMPLOYED PERSONS UNDER THE COVERAGE OF THE NEW YORK STATE WORKERS' COMPENSATION LAW

To: (Print name and address of insurance carrier)

THIS ELECTION IS EFFECTIVE AS OF THE DATE FILED WITH THE INSURANCE CARRIER

TAKE NOTICE that under the provisions of Sec. 54, subd. 8, of the New York Workers' Compensation Law as amended, the partnership as defined in Section 10 of the Partnership Law of New York State or the limited liability partnership (LLP) or professional limited liability partnership (PLLP) or limited liability company (LLC) or professional limited liability company (PLLC) or sole proprietorship named below elects to bring the partners, members or self-employed persons listed herein under the coverage of the New York Workers' Compensation Law with respect to all policies issued to the partnership, LLP, PLLP, LLC, PLLC or sole proprietorship by the insurance carrier named above.

Name of Partnership, LLP, PLLP, LLC, PLLC or Sole Proprietorship_____

Address_____
(County Where Principal Office is Located)

☐ This is a sole proprietorship having employees required to be covered under the NYS Workers' Compensation Law.

☐ This is a partnership as defined in Section 10 of the Partnership Law of New York State, having employees required to be covered under the NYS Workers' Compensation Law. This is not a limited partnership.

☐ This is a limited liability partnership or professional limited liability partnership having employees required to be covered under the NYS Workers' Compensation Law.

☐ This is a limited liability company or professional limited liability company having employees required to be covered under the NYS Workers' Compensation Law.

PARTNERS, MEMBERS OR SELF-EMPLOYED PERSONS TO BE INCLUDED IN POLICY
Name and Address of partners, members, or self-insured persons included in policy. Copy of this notice should be sent to each person named below.

I am a ☐ general partner ☐ sole proprietor ☐ member ☐ other (specify)_____

of the herein named firm or company and certify that the above election to include partners, members or self-employed persons as set forth above, was duly made by the partnership, company, or sole proprietorship and was entered upon the records of the firm or company.

Name of Firm or Company_____Date_____

_____
(Signature) Type Name and Title Telephone No.

PLEASE NOTE
This form applies only to the partners, members or self-employed persons here certified and should be sent at once to the insurance carrier. A new Form C-105.32 must be filed whenever new or additional partners, members or self-employed persons are to be included or when the insurance carrier is changed. For copy of Sec. 54, subd. 8, of the Workers' Compensation law and Sec.10 of the Partnership Law see reverse side.

SECTION 54, SUBDIVISION 8 OF THE NEW YORK WORKERS' COMPENSATION LAW

Section 54, Subd. 8

"A self-employed person or a partner of a partnership as defined in section ten of the partnership law but not including a limited partner, having other persons who are employees required to be covered under this chapter may be included in the compensation insurance contract or covered under a certificate of self-insurance. Such election shall be made by any such partnership or sole proprietorship filing with the insurance carrier or the chairman in the case of self-insurance upon a form prescribed by the chairman of the workers' compensation board, a notice that the partnership or sole proprietorship elects to include the partner or partners or the self-employed person named in the notice in the coverage of this chapter. Such election shall be effective with respect to all policies issued to such partnership or sole proprietorship by such insuance carrier as long as it shall continuously insure the employees of the partnership or sole proprietorship. Such election shall be final and binding upon the partner or self-employed person named in the notice untill revoked by the partnership or sole proprietorship. A self-employed person or a partner of a partnership having no other persons who are employees required to be covered under this chapter shall be deemed to be excluded from coverage under this chapter unless he elects to be covered. Such coverage may be effected by obtaining an insurance policy.

The self-employed persons or partners of a partnership brought within the coverage of the insurance contract, and the dependents of any such self-employed persons or partners of a partnership shall have the same rights and remedies as any employee or his dependents and shall be entitled to compensation and medical care as provided by this chapter, and the insurance carrier shall be liable therefor and for payments into the special funds provided in this chapter as in the case of an employee."

SECTION 10 OF THE NEW YORK PARTNERSHIP LAW

Section 10. Partnership Defined

"1. A partnership is an association of two or more persons to carry on as co-owners a business for profit.

2. But any association formed under any other statute of this state, or any statute adopted by authority, other than the authority of this state, is not a partnership under this chapter, unless such association would have been a partnership in this state prior to the adoption of this chapter; but this chapter shall apply to limited partnerships except in so far as the statutes relating to such partnership are inconsistent herewith."

State of New York
WORKERS' COMPENSATION BOARD

NOTICE OF ELECTION OF A CORPORATION WHICH IS REQUIRED TO HAVE COVERAGE FOR ITS EMPLOYEES UNDER THE NEW YORK STATE WORKERS' COMPENSATION LAW TO EXCLUDE THE SOLE SHAREHOLDER-OFFICER OR ONE OF THE TWO OR BOTH EXECUTIVE OFFICERS-SHAREHOLDERS OF THE CORPORATION FROM SUCH COVERAGE

To: (Print name and address of insurance carrier)

TAKE NOTICE that under the provisions of Section 54, subdivision 6, of the Workers' Compensation Law as amended, the corporation named below elects to exclude the executive officer(s) named below from coverage under the New York State Workers' Compensation Law with respect to all the policies issued to the corporation by the insurance carrier named above.

Name of Corporation _____

Address of Corporation _____

Incorporated Under the Laws of the State of _____

Type: ☐ One-person corp. ☐ Two-person corp. (A two-person corporation may elect to exclude **one or both** executive officers, provided that between them they own all the stock in the corporation, and that each officer owns **at least one share of stock**.)

ExecutiveOfficer(s) to be Excluded from Policy
1. Name _____ Title _____
2. Name_____ Title _____

CERTIFICATION

USE FOR ONE-PERSON CORPORATION

I, _____ (Name), certify that I am the sole executive officer of the above-named corporation; that I have been since _____ (Date) the sole owner of all issued and outstanding stock of the corporation and hold all the offices pursuant to paragraph (e) of Section 715 of the Business Corporation Law. (Affix corporate seal below, if you have one.)

_____ _____ _____
Signature of Officer | Date | Telephone No.

USE FOR TWO-PERSON CORPORATION

We, _____ (Name), _____ (Title) and _____ (Name), _____ (Title) certify that we are the two executive officers of the above-named corporation, having been duly appointed by corporate resolution; that we have been since _____ (Date) the sole owners of all issued and outstanding stock and that each of us owns at least one share of stock of the corporation, and that we hold all of the offices pursuant to paragraph (e) of Section 715 of the Business Corporation Law. (Affix corporate seal below, if you have one.)

_____ _____ _____
Signature of Officer | Date | Telephone No.

_____ _____ _____
Signature of Officer | Date | Telephone No.

THIS ELECTION IS FINAL AND BINDING UPON THE OFFICER(S) NAMED UNTIL REVOKED BY THE CORPORATION.

CORPORATE SEAL*

See reverse side for relevant portions of Sec. 54, subd. 6 (WCL) and Sec. 715, Par. (e) of the Business Corporation Law.

*If the corporation does not have a seal, check here ☐

Section 54, Subdivision 6 of the New York State Workers' Compensation Law

b. An executive officer of any corporation who at all times during the period involved owns all of the issued and outstanding stock of the corporation and holds all of the offices pursuant to paragraph (e) of section 715 of the business corporation law and who is the executive officer of a corporation having other persons who are employees required to be covered under this chapter shall be deemed to be included in the compensation insurance contract or covered under a certificate of self-insurance unless the officer elects to be excluded from the coverage of this chapter. Such election shall be made by the corporation filing a notice that the corporation elects to exclude the executive officer of such corporation named in the notice from coverage of this chapter. Such election shall be filed with the insurance carrier or the chair in the case of self-insurance upon a form prescribed by the chair of the workers' compensation board. Such election shall be effective with respect to all policies issued to such corporation by such insurance carrier as long as it shall continuously insure the corporation and shall be final and binding upon the executive officer named in the notice until revoked by the corporation in accordance with paragraph a of this subdivision.

d. Any two executive officers of a corporation who at all times during the period involved between them own all of the issued and outstanding stock of the corporation and hold all such offices, provided, however that each officer must own at least one share of stock, who are the executive officers of such corporation having other persons who are employees required to be covered under this chapter shall be deemed to be included in the compensation insurance contract or covered under a certificate of self-insurance unless one or both the officers elect to be excluded from the coverage of this chapter. Such election shall be made by any such corporation filing a form prescribed by the chair of the workers' compensation board with the insurance carrier or the chair in the case of self-insurance giving notice that the corporation elects to exclude one or both of the executive officers of such corporation named in the notice from the coverage of this chapter. Such election shall be effective with respect to all policies issued to such corporation by such insurance carrier as long as it shall continuously insure the corporation and shall be final and binding upon the executive officers as named in the notice until revoked by the corporation. If such election is revoked, it shall be in writing on a form prescribed by the chair and shall be filed with the chair and the insurance carrier. Such revocation shall not be effective until thirty days after such filing.

Section 715, Paragraph (e) of the Business Corporation Law

Any two or more offices may be held by the same person, except the offices of president and secretary. When all of the issued and outstanding stock of the corporation is owned by one person, such person may hold all or any combination of offices.

State of New York
WORKERS' COMPENSATION BOARD

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

REVOCATION OF ELECTION OF A CORPORATION WHICH IS REQUIRED TO HAVE COVERAGE FOR ITS EMPLOYEES UNDER THE NEW YORK STATE WORKERS' COMPENSATION LAW TO EXCLUDE THE SOLE SHAREHOLDER-OFFICER OR ONE OF THE TWO OR BOTH EXECUTIVE OFFICERS-SHAREHOLDERS OF THE CORPORATION FROM SUCH COVERAGE

To: CHAIRMAN, WORKERS' COMPENSATION BOARD

To: (Print name and address of insurance carrier)

THIS REVOCATION IS EFFECTIVE 30 DAYS AFTER THE DATE FILED WITH THE CHAIRMAN WORKERS' COMPENSATION BOARD.

TAKE NOTICE that under the provisions of Sec. 54, subd. 6, of the New York Workers' Compensation Law, the corporation named below hereby revokes, effective as provided by law, the election now in effect to bring the executive officers described herein within the coverage of the New York Workers' Compensation Law with respect to all policies issued to the corporation by the insurance carrier named above.

Name of Corporation.....

Address.....

Incorporated Under the Laws of the State of.....

Type: ☐ One-person corporation ☐ Two-person corporation

NAMES AND ADDRESSES OF EXECUTIVE OFFICERS INCLUDED IN POLICY

Name..... Title.....

Address.....

Name..... Title.....

Address.....

Name..... Title.....

Address.....

I.....of the herein named corporation,
Name Title

certify that the above revocation of election to include the executive officers as described above, was duly made at a meeting of the Board or other executive body duly authorized by law to take such action, and entered in the minutes of the corporation and that copies of this notice have been filed this day with the Chairman, Workers' Compensation Board, the insurance carrier named above and each of the executive officers affected.

By..... Tel. No:.....

Title..... Date.....

CORPORATE SEAL*

*If the corporation does not have a seal, check here ☐

NOTE:
This form applies only to the executive officers here certified and should be sent at once to the Chairman, Workers' Compensation Board, Attention: Compliance Bureau, 328 State Street, Schenectady, NY 12305 with copies to the insurance carrier and each of the executive officers concerned. For relevant portions of Sec. 54, subd.6 of the law see reverse side.

Section 54, Subdivision 6 of the New York State Workers' Compensation Law

b. An executive officer of any corporation who at all times during the period involved owns all of the issued and outstanding stock of the corporation and holds all of the offices pursuant to paragraph (e) of section 715 of the business corporation law and who is the executive officer of a corporation having other persons who are employees required to be covered under this chapter shall be deemed to be included in the compensation insurance contract or covered under a certificate of self-insurance unless the officer elects to be excluded from the coverage of this chapter. Such election shall be made by the corporation filing a notice that the corporation elects to exclude the executive officer of such corporation named in the notice from coverage of this chapter. Such election shall be filed with the insurance carrier or the chair in the case of self-insurance upon a form prescribed by the chair of the workers' compensation board. Such election shall be effective with respect to all policies issued to such corporation by such insurance carrier as long as it shall continuously insure the corporation and shall be final and binding upon the executive officer named in the notice until revoked by the corporation in accordance with paragraph a of this subdivision.

d. Any two executive officers of a corporation who at all times during the period involved between them own all of the issued and outstanding stock of the corporation and hold all such offices, provided, however that each officer must own at least one share of stock, who are the executive officers of such corporation having other persons who are employees required to be covered under this chapter shall be deemed to be included in the compensation insurance contract or covered under a certificate of self-insurance unless one or both the officers elect to be excluded from the coverage of this chapter. Such election shall be made by any such corporation filing a form prescribed by the chair of the workers' compensation board with the insurance carrier or the chair in the case of self-insurance giving notice that the corporation elects to exclude one or both of the executive officers of such corporation named in the notice from the coverage of this chapter. Such election shall be effective with respect to all policies issued to such corporation by such insurance carrier as long as it shall continuously insure the corporation and shall be final and binding upon the executive officers as named in the notice until revoked by the corporation. If such election is revoked, it shall be in writing on a form prescribed by the chair and shall be filed with the chair and the insurance carrier. Such revocation shall not be effective until thirty days after such filing.

Section 715, Paragraph (e) of the Business Corporation Law

Any two or more offices may be held by the same person, except the offices of president and secretary. When all of the issued and outstanding stock of the corporation is owned by one person, such person may hold all or any combination of offices.