

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

NOTICE OF COMPLIANCE
TO EMPLOYEES

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

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

WORKERS' COMPENSATION BOARD OFFICES

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

* DOWNSTATE MAILING ADDRESS

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

Statewide Fax: 877-533-0337

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 días 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 compañía 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. 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. Si tiene dificultad en conseguir un formulario de reclamación o
- 9. necesita ayuda para llenarlo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuníquese con la oficina mas cercana de la Junta.

ROBERT E. BELOTEN, CHAIR/PRESIDENTE

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

Berkley Industrial Comp
P. O. Box 660847
Birmingham, AL 35266
(800)448-5621

Name of employer (Nombre del patrono)

For Insurance Carriers ONLY: Policy No.....
Policy in Force fromto

**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.

NEW YORK WORK INJURY REPORTING PROCEDURES

This Claim Packet is provided for your use in reporting employee work related injuries. Copy the enclosed forms as needed.

Employer's First Report of Injury or Occupational Disease (C-2)

This form must be completed at the time of the injury and/or immediately upon the employer's knowledge of the injury. The original form should be immediately mailed, faxed or e-mailed to us. As an alternative, Employer's First Reports of Injury or Occupational Disease (FROI's) may be submitted to us online at: www.berkindcomp.com. Online Reporting Instructions are enclosed. Maintain a copy of the FROI for your records. Keep a separate file for each workers' compensation claim.

Supervisor's Report

The supervisor should fill out this form as soon as the accident is reported. The original should be submitted with the FROI. If the FROI is reported online, then please mail, fax or e-mail the Supervisor's Report to us. Maintain a copy for your records. If you utilize another version of a supervisor's report, it may be substituted for the enclosed report.

Wage Statement (C-240)

The Wage Statement must be completed on claims involving lost time from work.

Please contact our claims department if you have questions about completing the Wage Statement.

Do not delay reporting the Employer's First Report of Injury or Occupational Disease for completion of the Wage Statement.

Work Status

You must immediately notify Berkley Industrial Comp if an employee begins to lose time from work. You must immediately notify us of the date the employee is scheduled to return to any type work (full duty, modified duty, light duty).

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

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

Employee Name _____

WCB Case Number (JCN) _____ Date of Injury _____

Claim Administrator Claim Number _____

INSURER / CLAIM ADMINISTRATOR INFORMATION

Insurer Name _____ Insurer ID _____

Name _____

Info/Attn _____

Address _____

City _____ State _____

Postal Code _____ Country _____

Claim Admin ID _____

EMPLOYEE INFORMATION

First Name _____ Middle Name/Initial _____

Last Name _____ Suffix _____

Mailing Address _____

City _____ State _____

Postal Code _____ Country _____

Phone Number _____ Date of Hire _____

Date of Birth _____ Gender Male Female Unknown

Employee SSN _____

Occupation Description _____

CLAIM INFORMATION

Time of Injury _____ Date Employer Had Knowledge of the Injury _____
Employment Status _____ Date Employer Had Knowledge of Date of Disability _____
Estimated Weekly Wage _____ Number of Days Worked Per Week _____
Work Week Type Standard Work Week Fixed Work Week Varied Work Week
Work Days Scheduled Sun Mon Tues Wed Thurs Fri Sat

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes No Employer Paid Salary in Lieu of Compensation Yes No
Initial Treatment No Medical Treatment Minor On-Site Treatment By Employer Minor Clinic/Hospital Treatment
 Emergency Evaluation Hospitalization Greater Than 24 Hours Future Major Medical/Lost Time Anticipated
Death Result of Injury Yes No Unknown Date of Death _____ Number of Dependents _____
Nature of Injury (i.e. Laceration, Burns, Fracture, Strain, etc) _____
Part of Body (i.e. left arm, right foot, head, multiple, etc) _____
Cause of Injury (i.e. Motor Vehicle, Machine, Strain or Injury by lifting, etc) _____
Accident/Injury Description (see instructions)

WORK STATUS

Initial Date Last Day Worked _____ Return To Work Type Actual Released
Initial Date Disability Began _____ Physical Restrictions Yes No
Initial Return to Work Date _____ Return To Work Same Employer Yes No

ACCIDENT LOCATION AND WITNESSES

Premises (see instructions) Employer Lessee Other
Organization Name _____
Street _____ State _____
City _____ Postal Code _____
County _____ Country _____
Location Narrative _____

Witnesses _____ **Business Phone Number** _____

EMPLOYER INFORMATION

Name _____ Employer FEIN _____
UI Number _____ Manual Classification Code _____
Industry Code _____
Info/Attn _____
Mailing Address _____
City _____ State _____
Postal Code _____ Country _____
Physical Addr _____
City _____ State _____
Postal Code _____ Country _____
Contact Name _____
Contact Business Phone Number _____

INSURED INFORMATION

Insured Name _____ Insured FEIN _____
Insured Type Insured Self-Insured Uninsured Insured Location ID _____
Policy Number ID _____
Policy Effective Date _____ Policy Expiration Date _____

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

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

If prepared by the employer:

Signature of Person Preparing Form _____ Date _____
Print Name _____
Title _____ Phone Number _____

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

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

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

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

Employee of the Same Class

First Name: _____ Last Name: _____ MI: _____

Job Title: _____

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



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

CLAIM INFORMATION

Date of Injury/Illness: Enter the date the injured worker was injured or noticed they were ill. Enter the date in month/day/year format.

Include the four digit year.

WCB Case #: The Workers' Compensation Board Case number.

Insurer Case #: The Claim Administrator Claim (Carrier Case) number.

INJURED WORKER INFORMATION

Last Name, First Name, MI: Enter the injured worker's full legal name.

Mailing Address: Enter the injured worker's full address, including PO Box, if applicable, city or town, state, zip code.

Social Security #: Enter the injured worker's Social Security Number.

INSURER INFORMATION

Insurer Name: Enter the name of the Workers' Compensation Insurer or Self-Insured Group name.

Mailing Address: Enter the insurer or claims administrator address, including PO Box, if applicable, city or town, state, zip code.

Phone #: Enter the insurer phone number, including area code and extension, if applicable.

Fax #: Enter the insurer fax number, including area code, if applicable.

Email Address: Enter the insurer or claims administrator email address.

EMPLOYER INFORMATION

Employer Name: Enter the name of the injured worker's employer.

Mailing Address: Enter the employer's full address, including PO Box, if applicable, city or town, state, zip code.

Phone #: Enter the employer phone number, including area code and extension, if applicable.

Federal Tax ID #: Enter the employer Federal Tax ID number.

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

PREPARED BY

Last Name, First Name, MI: Enter the preparer's full legal name.

Employer Name: Enter the name of the preparer's employer.

Official Title: Enter the preparer's official title.

Phone #: Enter the preparer's phone number, including area code and extension, if applicable.

Email Address: Enter the preparer's email address.

Date of this Report: Enter the date this report was prepared.

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

Injured Worker Payroll

Week Ending Date: Enter the week ending dates for each of the 52 weeks immediately prior to the date of injury/illness.

Days Compensated (including paid time off): In the "Days Paid" column, give the number of days worked in the employment for which the worker was paid, including paid time off. If days paid (compensated) is zero, provide an explanation in question 7 on page 1. Do not include accrued time such as vacation time.

Gross Amount Paid including Overtime: Enter the injured worker's average weekly gross pay (prior to taxes), including overtime. Do not use the injured worker's take-home pay. "Wages" means the money rate at which the service rendered by the injured worker is compensated under the contract of hire in force at the time of the injury.

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

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

Submit by mail or electronically directly to:

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

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