NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

You were injured at work. What now?

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

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

Your Responsibilities

- You must notify your employer, in writing, when, where and how you were injured. Do this as soon as possible within 30 days of injury.
- Advise your health care providers that you have a work-related injury, and give the name of your employer. Do not pay for your care or use other health insurance. Your health care provider will file medical reports with the Board and with your employer or its insurance carrier. If your case is disputed, the Board needs a medical report on your injury to begin resolving your claim.
- You should file an **Employee Claim** (Form C-3) reporting your injury to the Board as soon as possible (you must notify the Board of your injury or illness within two years). If you injured the same body part before, or had a similar illness, you must also file a **Limited Release of Health Information** (Form C-3.3).

Two ways to file a Claim

Visit wcb.ny.gov and select File a Claim.

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

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

Health Care and Travel Bills

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

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

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

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

Benefits for Lost Wages

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

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

You may hire an attorney or licensed representative for help with your claim, but it isn't required. The Board sets their fees, which will be deducted from your lost wages award. You or your family should not pay anything directly to your attorney or licensed representative.

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

Help is Available

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

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

What's Next?

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

IMPORTANT CONTACT INFORMATION

Workers' Compensation Board, including Disability Benefits	(877) 632-4996	general_information@wcb.ny.gov
		wcb.ny.gov

The Board's eCase application enables you to view the contents of your case folder online. For general information or to register for eCase, please visit the Board's website at wcb.ny.gov.

NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

NEW YORK STATE Workers' Compensation Board

Employee Claim

State of New York - Workers' Compensation Board

C-3

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: ☐ Male ☐ Female

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

B. YOUR EMPLOYER(S)

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

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

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

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

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

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

1. What was your job title or description? _____

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

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

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

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

D. YOUR INJURY OR ILLNESS

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

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

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

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

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

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

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

D. YOUR INJURY OR ILLNESS *continued*

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

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

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

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

E. RETURN TO WORK

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

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

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

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

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

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

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

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

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

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

Print Name: _____ Title: _____

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

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 | Workers' Compensation Board

Divulgación limitada de información sobre la salud
(HIPAA)

C-3.3

Estado de NuevaYork - Junta de Compensación Obrera (WCB)

WCB Case No. (if you know it) (Número de caso WCB *[si lo sabe]*)

Al reclamante: Si usted recibió tratamiento por una lesión anterior en la misma parte del cuerpo o por una enfermedad similar a la que motiva ahora su reclamación, complete este formulario. Este formulario les permite a los proveedores de salud que usted señala a continuación divulgar a la compañía de seguros de compensación obrera de su empleador la información sobre su salud relacionada con su lesión/enfermedad anterior. La Ley federal HIPAA (Ley de portabilidad y responsabilidad del seguro de salud de 1996) establece que usted tiene derecho a recibir una copia de este formulario. Si no comprende este formulario, hable con su representante legal. Si no tiene un representante legal, el Representante de los obreros lesionados de la Junta de Compensación Obrera puede ayudarlo. Llame al 800-580-6665.

Al proveedor de salud: Una **copia** de esta divulgación, redactada según lo que establece la ley HIPAA, le permite divulgar información sobre la salud. Si envía los registros al asegurador de compensación obrera del empleador en respuesta a la presente divulgación, también debe enviar por correo copias al representante legal del reclamante. (Si a continuación no se especifica un representante legal, envíe las copias al reclamante). Los proveedores de salud que divulgan los registros deben cumplir con las leyes del estado de Nueva York y la HIPAA.

Esta divulgación es:

- **Voluntaria.** Su(s) proveedor(es) de salud deben otorgarle la misma atención, condiciones de pago y beneficios, independientemente de que usted firme este formulario o no.
- **Limitada.** Le otorga a su(s) proveedor(es) de salud permiso para divulgar únicamente los registros médicos que se relacionen con la enfermedad/afección anterior que usted describe a continuación.
- **Temporal.** Termina cuando se otorgue o desestime su actual reclamación de compensación y se hayan agotado todas las apelaciones.
- **Revocable.** Usted puede cancelar esta divulgación en cualquier momento. Para hacerlo, envíe una carta al (a los) proveedor(es) de salud que se indican en este formulario. Además, envíe una copia de su carta a la compañía de seguros de compensación obrera de su empleador y a la Junta de Compensación Obrera. *Nota: No podrá cancelar esta divulgación en lo que se refiere a registros médicos que ya se hayan provisto.*
- **Solamente para registros.** Le otorga a su(s) proveedor(es) de salud que se indica(n) en este formulario permiso para enviar copias de sus registros de salud a la compañía de seguros de compensación obrera de su empleador.

Este formulario NO autoriza a su(s) proveedor(es) de salud a divulgar los siguientes tipos de información:

- **Información relacionada con el VIH**
- **Notas de terapia psicológica**
- **Tratamientos por abuso de alcohol o drogas**
- **Tratamiento de salud mental** (a menos que usted lo indique a continuación)
- **Información verbal** (sus doctores no pueden hablar con nadie sobre su información de salud)

Los registros médicos divulgados se incorporarán a su expediente de compensación obrera y son confidenciales conforme a la Ley de compensación obrera.

CONTESTA LAS SIGUIENTES PREGUNTAS, EN INGLÉS SI ES POSIBLE, EN LOS ESPACIOS PROVISTOS Y FIRMA AL FRENTE DE LA FORMA.

A. YOUR INFORMATION (Claimant) INFORMACIÓN PERSONAL (Reclamante)

1. Name (Nombre)
2. Social Security Number (Número de seguro social)
3. Mailing Address (Dirección postal)
4. Date of Birth (Fecha de nacimiento)
5. Date of the current injury/illness (Fecha de la lesión/enfermedad actual)
6. Current injury/illness, including all body parts injured (Descripción de la lesión/enfermedad actual, incluyendo todas las partes del cuerpo lesionadas)
7. Your legal representative's name and address (if any) (Nombre y dirección de su representante legal [si corresponde])

Check here if you allow your health provider(s) to release ***mental health care*** *information. (Marque aquí si autoriza a su(s) proveedor(es) de salud a divulgar información sobre* ***tratamientos de salud mental****.)*

B. YOUR HEALTH CARE PROVIDERS

(List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers, attach their contact information to this form.

SU(S) PROVEEDOR(ES) DE SALUD (Enumere todos los proveedores de salud que le han tratado por lesiones previas a las mismas areas del cuerpo ó por enfermedades semejantes.Si son más de 2 proveedores, adjunte su información de contacto a este formulario.)

1. Provider (Proveedor de salud)
2. Phone Number (Nº de teléfono)
3. Mailing Address (Dirección postal)
4. Other provider (if any) (Otro proveedor [si corresponde])
5. Phone Number (Nº de teléfono)
6. Mailing Adress (Dirección postal)

C. READ AND SIGN BELOW

I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above. **LEA Y FIRME A CONTINUACIÓN.** Por la presente solicito que los proveedores de salud aquí enumerados le provean al asegurador de compensación obrera de mi patrono copias de todos los records médicos relacionados a cualquier lesión/enfermedad aquí enumeradas.

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below: (**Si el reclamante no puede firmar**, la persona que firme el formulario en su nombre y representación debe llenar y firmar a continuación)

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

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

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

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

Instructions for Completing Employee Claim (Form C-3)

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

Section A - Your Information (Employee):

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

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

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

Section B - Your Employer(s):

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

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

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

Section D - Your Injury or Illness:

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

Section E - Return to Work:

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

Section F - Medical Treatment for This Injury or Illness:

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

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

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

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

Your Rights:

1. Generally, you are entitled to be treated by a doctor of your choice, provided he/she is authorized by the Board. If your employer is involved in a preferred provider organization (PPO) arrangement, you must obtain initial treatment from the preferred provider organization which has been designated to provide health care services for workers' compensation injuries.
2. DO NOT pay your doctor or hospital. Their bills will be paid by the insurance carrier if your case is not disputed. If your case is disputed, the doctor or hospital must wait for payment until the Board decides your case. In the event you fail to prosecute your case or the Board decides against you, you will have to pay the doctor or hospital.
3. You are also entitled to be reimbursed for drugs, crutches, or any apparatus properly prescribed by your doctor and for carfares or other necessary expenses going to and from your doctor's office or the hospital. (Get receipts for such expenses.)
4. You are entitled to compensation if your injury keeps you from work for more than seven days, compels you to work at lower wages, or results in permanent disability to any part of your body.
5. Compensation is payable directly and without waiting for an award, except when the claim is disputed.
6. Injured workers or dependents of deceased workers may represent themselves in matters before the Board or may retain an attorney or licensed representative to represent them. If an attorney or licensed representative is retained, his/her fee for legal services will be reviewed by the Board and if approved will be paid by the employer or insurance company out of any compensation benefits due. Injured workers or dependents of deceased workers should not directly pay anything to the attorney or licensed representative representing them in a compensation case.
7. If you need help returning to work, or with family or financial problems because of your injury, contact the Workers' Compensation Board office nearest you and ask for a rehabilitation counselor or social worker.

This form should be filed by sending directly to the address listed below:
New York State Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Toll-Free Number: 877-632-4996

Your company's workers' compensation insurance carrier is The New York State Insurance Fund (NYSIF), which has a contract with CVS Caremark, a pharmacy benefits manager (PBM) that offers convenient prescription filling services.

NYSIF has implemented an instant enrollment or "short-fill" service with CVS Caremark. The new service allows injured workers immediate acceptance by any pharmacy in the CareComp pharmacy network administered by CVS Caremark. Although New York law does not require us to provide this benefit, we have elected to provide a limited number of cost-effective medication benefits for new claims filed for **work-related injuries or illnesses** in order to help injured workers get through the first, difficult days after an injury and before the claim is accepted.

When an employee sustains a work-related injury, the form on the other side of this page (Workers' Compensation Temporary Prescription Services ID) may be used to fill prescriptions at any participating pharmacy in the CareComp Network of CVS Caremark . It makes **getting prescriptions for your work-related injury** very easy.

Step 1: Employer fills in:
- Employer's Name
- Policy Number

Step 2: Injured employee fills in his/her:
- Social Security Number
- Date of Injury
- Date of Birth
- Name
- Mailing Address

Step 3: Injured employee brings to pharmacy:
- Completed temporary ID form
- Prescription(s) for work-related injury

Step 4: Within 10 days of the New York State Insurance Fund's confirmation of the accident, the injured employee will receive a packet from CVS Caremark. The packet will contain a permanent ID card that should be used when filling prescriptions for the work-related injury.

Note: Injured workers can quickly find local participating pharmacies by visiting: **http://www.wcrxpharmacylocator.com** or by calling the CVS Caremark 24-hour patient care hotline at 1-866-493-1640.

If you have any questions about this form, please contact NYSIF, your workers' compensation carrier, at 1-888-875-5790.

NYSIF New York State Insurance Fund

CVS CAREMARK

Workers' Compensation Temporary Prescription Services ID
Important Information

ATTENTION **INJURED WORKER**

This Workers' Compensation Temporary Prescription Services ID form MUST BE PRESENTED to your pharmacist when you fill your initial prescription(s). If you have questions or need to locate a participating pharmacy, please contact CVS Caremark Customer Service at 1-866-493-1640.

ATENCIÓN: TRABAJADOR LESIONADO

Este formulario de Identificación para Servicios Temporales de Prescripción de Recetas por Compensación del Trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es). Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de CVS Caremark, en el teléfono 1-866-493-1640.

Pharmacist – When form is completed, fax to CVS Caremark at **1-866-493-1644 or phone in at 1-866-493-1640**

New York State Insurance Fund	**Group#: NYSIF**
Attention: All items below must be completed.	
EMPLOYER'S NAME:	INJURED WORKER'S NAME:
_____	_____
	FIRST MI LAST:
EMPLOYER's WORKERS' COMPENSATION POLICY NUMBER: _____	INJURED WORKER'S MAILING ADDRESS:
DATE OF INJURY: __ __ / __ __ / __ __ __ __ MM / DD / CCYY	_____ STREET:
INJURED WORKER'S DATE OF BIRTH: __ __ / __ __ / __ __ __ __	_____ CITY, STATE ZIP
ID#: _____ Injured Worker's Social Security Number	*Help Desk: This is a POS Program through CVS Caremark only. For Assistance call the CVS Caremark Help Desk at: 866.493.1640*

Attention Pharmacist:

New York State Insurance Fund's prescription program is administered by CVS Caremark. The following are the steps necessary to submit a prescription for New York State Insurance Fund claimants.

Please follow the action steps listed below to enter the claim.

Step 1	Enter Bin Number 610235
Step 2	Enter PCN: WRK
Step 3	ID: Injured Worker' Social Security Number

NEED ASSISTANCE? **Pharmacist**, if you have any questions while processing the claim, please call the CVS Caremark Help Desk at **1-866-493-1640.**

State of New York
WORKERS' COMPENSATION BOARD

Notice of Right to Select a Workers' Compensation Board Authorized Health Care Provider

Injured Employee's Name	Injured Employee's Social Security No.	Date of Accident
Employer's Name and Address		

To the Injured Employee:

For the treatment of your work-related injury or illness, you may choose any physician, podiatrist, chiropractor, or psychologist (upon referral from an authorized physician) who is Workers' Compensation Board authorized and who is accepting workers' compensation patients.

While you may choose to utilize a network or provider which is recommended by your employer or its workers' compensation insurance carrier or to permit your employer to select a provider on your behalf, you may, at any time, change your health care provider without jeopardizing your workers' compensation claim for benefits.

Signature of Injured Employee	Date	Signature of Witness	Date

Please note: It is not necessary for you to sign this consent form if your employer is (i)participating in a certified preferred provider organization (PPO) under Article 10-A of theWorkers' Compensation Law, or (ii) participating in the alternative dispute resolution (ADR)pilot program under section 25(2-c) of the Workers' Compensation Law. In accordance withthese statutory programs, except in emergency situations, you must obtain at least initialtreatment for any workers' compensation injury or illness from the certified network(s) orproviders designated by your employer.

To the Employer:

The employer shall provide the above-named injured employee with a copy of this signed form and shall maintain the original form in the employer's records where it may be inspected by the Workers' Compensation Board at any time. This form shall not be submitted to the Workers' Compensation Board nor shall it be executed prior to the occurrence of this employee's work-related injury or illness.

The Workers' Compensation Board employs and serves people with disabilities without discrimination.

Stato di New York
WORKERS' COMPENSATION BOARD

Informativa sul diritto di scelta di un professionista/struttura sanitaria autorizzato dalla Workers' Compensation Board

Nome del dipendente vittima di infortunio	N. di previdenza sociale del dipendente vittima di infortunio	Data dell'incidente
Nome e indirizzo del datore di lavoro		

Al dipendente vittima di infortunio:

Per il trattamento del proprio infortunio o malattia correlata alla professione, sarà possibile rivolgersi (su segnalazione del medico autorizzato) ai medici, podologi, chiropratici o psicologi autorizzati dalla Workers' Compensation Board che accettano di curare i pazienti coperti da assicurazione sul lavoro.

Anche nell'eventualità in cui si decida di rivolgersi a una rete di assistenza sanitaria o a un professionista/struttura sanitaria indicato dal proprio datore di lavoro o dalla rispettiva compagnia assicurativa per infortuni sul lavoro, o se, invece, si consente al proprio datore di lavoro di scegliere un professionista/struttura sanitaria per proprio conto, sarà comunque possibile rivolgersi a diverso professionista/struttura sanitaria in qualsiasi momento senza compromettere in alcun modo la richiesta di indennizzo per infortunio sul lavoro.

Firma del dipendente vittima di infortunio	Data	Firma del testimone	Data

Attenzione: Non è necessario firmare il modulo di consenso se il proprio datore di lavoro: (1) è membro di organizzazione di prestatori di assistenza sanitaria convenzionati (PPO) ai sensi dell'Articolo 10-A della Workers' Compensation Law; (2) partecipi a programma pilota di soluzione alternativa delle dispute (ADR) secondo quanto stabilito nella sezione 25(2-c) della Workers' Compensation Law. Secondo tali programmi istituzionali, fatto salvo situazioni di emergenza, il trattamento iniziale di qualsiasi tipo di infortunio sul lavoro o malattia correlata alla professione Le dovrebbe essere garantito dalle reti di assistenza certificate o dai professionisti/strutture designati dal suo datore di lavoro.

Al datore di lavoro:

Il datore di lavoro è tenuto a fornire al suddetto dipendente, vittima di infortunio sul lavoro, copia firmata del presente modulo e conservare l'originale nei propri archivi per eventuali ispezioni da parte della Workers' Compensation Board. Non convalidare né inviare il modulo alla Workers' Compensation Board fintanto che il dipendente non subisce danni fisici dovuti a infortuni sul lavoro o all'insorgere di malattie correlate alla professione.

La Workers' Compensation Board assume e serve persone affette da disabilità senza alcun tipo di discriminazione.

Get your claim payment by direct deposit!

Direct Deposit

New York State Insurance Fund

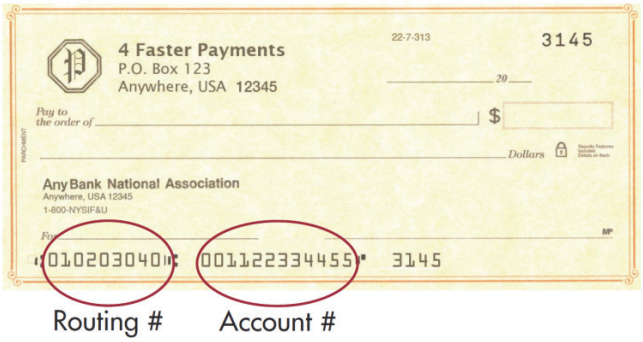
nysif.com

NYSIF offers direct deposit for claimants to receive workers' compensation benefits. In cooperation with your financial institution, NYSIF can deposit benefit payments directly to your bank account.

NYSIF DIRECT DEPOSIT INSTRUCTIONS
SECTION I
PLEASE READ CAREFULLY

REQUIREMENTS FOR TYPE OF ACCOUNT

Choose only one account: **Checking** or **Savings**. Complete all information in Section II, including your bank routing number (see check illustration) and account number. Check your financial institution if you need help completing this section.



CANCELLATION

This agreement remains in effect until canceled. You may cancel by writing to your case manager. You can locate your case manager at *nysif.com>CONTACT US>Contact Your Case Manager*, or by calling Customer Service at 1-888-875-5790.

This agreement may also be canceled by NYSIF or by your financial institution. In such case, you will receive checks in the mail.

CHANGES IN YOUR BANK ACCOUNT

It is your responsibility to notify NYSIF *immediately of any changes* in your account (e.g. change of account number, financial institution, etc.)

A change in account will take at least three weeks for processing. If you are changing financial institutions, you should maintain accounts at both your old and new financial institutions until the new financial institution receives your first Direct Deposit payment. If the account at the first financial institution is not maintained, you may experience a delay in payment until the new Direct Deposit authorization takes effect.

PERIODIC VERIFICATION

NYSIF may contact you periodically to make sure the right person is receiving payments and to ascertain if that person is still entitled to receive payments. If the payee is no longer living, NYSIF should be notified immediately.

NEW YORK STATE INSURANCE FUND **DIRECT DEPOSIT AUTHORIZATION APPLICATION**

TO RECEIVE DIRECT DEPOSIT OF BENEFITS, READ SECTION I OF THIS FORM, THEN PROVIDE THE REQUESTED INFORMATION IN SECTION II. CALL 1-888-875-5790 FOR QUESTIONS ABOUT THIS FORM.

SECTION II

NAME (FIRST, MIDDLE, LAST): **NYSIF CLAIM NUMBER:**

_____ _____

HOME ADDRESS (DO NOT USE PO BOX): _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

E-MAIL ADDRESS: _____

PHONE (DAY): _____ **PHONE** (NIGHT): _____

DIRECT DEPOSIT ACCOUNT SET UP (CHOOSE ONLY ONE): ☐ **CHECKING** ☐ **SAVINGS**

(FILL IN ALL INFORMATION INCLUDING YOUR ACCOUNT NUMBER AND BANK ROUTING NUMBER. CONTACT YOUR FINANCIAL INSTITUTION IF YOU NEED HELP WITH COMPLETING THIS SECTION.)

NAME OF FINANCIAL INSTITUTION: _____

ROUTING # _____ **ACCOUNT #** _____

DEPOSITOR/PAYEE CERTIFICATION & AUTHORIZATION

IN SIGNING THIS FORM, I AUTHORIZE MY NEW YORK STATE INSURANCE FUND PAYMENTS TO BE SENT TO THE FINANCIAL INSTITUTION NAMED ABOVE TO BE DEPOSITED INTO THE DESIGNATED ACCOUNT AT THE FINANCIAL INSTITUTION NAMED. I CERTIFY THAT I AM ENTITLED TO RECEIVE THE UNDERLYING COMPENSATION PAYMENTS OR SETTLEMENT PROCEEDS, AND CIRCUMSTANCES ENTITLING ME TO BENEFITS HAVE NOT CHANGED. IN THE EVENT THAT CIRCUMSTANCES WHICH WOULD AFFECT ENTITLEMENT TO RECEIVE PAYMENTS HAVE CHANGED, I MUST NOTIFY NYSIF.

SIGNATURE: _____ **DATE:** _____

MAIL COMPLETED APPLICATION TO:
DOCUMENT CONTROL CENTER
NEW YORK STATE INSURANCE FUND
1 WATERVLIET AVENUE EXT.
ALBANY, NY 12206-1649