

## Procedure for Reporting Workers' Compensation Injury Volunteer Ambulance Worker

### Volunteer Member Responsibilities:

1. Complete "Volunteer Ambulance Worker's Claim for Benefits" (Form VAW-3) – 1 page
2. Complete "Limited Release of Health Information" (Form C-3.3) – 1 page
3. Complete "Authorization to Obtain Information" (WC Form 5) – 1 page

❖ The 3 forms above should be provided to your squad supervisor immediately.

### If your injury requires medical care:

This packet contains forms that you will need to take with you to the treating provider & pharmacy.

Take a copy of "Workers' Compensation Encounter Form" (WC Form 10) with you to each doctor visit.

Tell your doctor or hospital to send all bills to the following address. Be sure to mark the date of injury clearly on all correspondence.

Warren County Self-Insurance, 1340 State Route 9, Lake George NY 12845

If you require pharmaceuticals for this injury, take the "Temporary Prescription Form" with you to the pharmacy.

Provide your squad supervisor with proper medical documentation if time away from work is recommended.

If your injury requires medical treatment, the Self-Insurance Department will mail you an information packet with your claim information.

### Squad Supervisor Responsibilities:

- If the injury is serious or the volunteer is expected to be out of work more than a day, call Self-Insurance immediately to alert them to the claim. Then follow up with the paper work as soon as possible.
- Confirm that the member has completed and given you the forms:
  - "Volunteer Ambulance Worker's Claim for Benefits" (Form VAW-3) – 1 page
  - "Limited Release of Health Information" (Form C-3.3) – 1 page
  - "Authorization to Obtain Information" (WC Form 5) – 1 page
- Advise and confirm that the member has retained forms:
  - "Claimant Information Packet" – 2 pages
  - "Workers' Compensation Encounter Form" – 1 page
  - The list of pharmacies – 1 page
- Complete the Employer Section on the "Temporary Prescription Form" page and return that page to the member
- Complete "Form C-2F – 3 pages
- Forward the completed Employee forms (3) and the C-2F form to Self-Insurance
- Notify Self-Insurance when employee returns to work OR if the employee's condition changes

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD  
**VOLUNTEER AMBULANCE WORKER'S CLAIM FOR BENEFITS**

SEE REVERSE  
FOR FILING  
INSTRUCTIONS

Does this claim involve disease or malfunction of the heart or of one or more coronary arteries? (Check one)  Yes  No

<small>W.C.B. CASE NO. (if known)</small>	<small>CARRIER CASE NO. (if known)</small>	<small>CARRIER CODE NO.</small>	<small>DATE OF INJURY</small>	<small>SOCIAL SECURITY NO.</small>
<small>First Name</small>		<small>Middle Initial</small>	<small>Last Name</small>	<small>Address (Give Number and Street, City, State, Zip Code)</small>
<small>Apt. No.</small>				
<b>1. VOLUNTEER AMBULANCE WORKER</b>				
<b>2. AMBULANCE COMPANY</b>				
<b>3. POLITICAL SUBDIVISION</b>				
<b>INFORMATION, REGULAR WORK</b>	4. (a) Marital Status _____ (b) Sex _____ (c) Date of Birth _____ (e) Tel. No. (____) _____			
	5. Describe in detail your duties in regular employment _____ _____			
	6. Your work week at time of injury was (check one) <input type="checkbox"/> 5 days <input type="checkbox"/> 6 days <input type="checkbox"/> 7 days <input type="checkbox"/> Other _____			
	7. Employer's name and address _____ _____			
<b>INJURY</b>	8. (a) Were you injured in the line of duty in the jurisdiction of your own ambulance district or political subdivision? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	(b) If you were injured in the line of duty involving assistance call from another locality, give name of other ambulance district or political subdivision _____			
<b>PLACE AND TIME</b>	9. Address where injury occurred _____ _____ County _____			
	10. Date of injury _____ at _____ o'clock _____ M			
<b>NATURE AND EXTENT OF INJURY</b>	11. State full nature and cause of injury _____ _____			
	12. Has injury resulted in amputation? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe _____			
	13. On what date did you stop work because of this injury? _____			
	14. Have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give date _____			
	15. (a) Does injury keep you from work? <input type="checkbox"/> Yes <input type="checkbox"/> No (b) Have you done any work during your disability? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>MEDICAL CARE</b>	16. (a) Did you receive medical care? <input type="checkbox"/> Yes <input type="checkbox"/> No (b) Are you now receiving medical care? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	17. (a) Are you now in need of medical care? <input type="checkbox"/> Yes <input type="checkbox"/> No (b) Name and address of attending doctor _____ _____			
	18. If you were treated in a hospital, give name and address _____ _____			
<b>VOLUNTEER AMBULANCE WORKERS' BENEFITS</b>	19. Have you received volunteer ambulance workers' benefits payments for the injury reported above? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	20. Are you now receiving volunteer ambulance workers' benefits payments? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	21. Do you claim further volunteer ambulance workers' benefits payments? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain _____ _____			
<b>NOTICE</b>	22. Have you given Notice to Liable Pol. Subdivision of Vol. Ambulance Worker's Injury or Death (Form VAW-1) to the political subdivision liable for the payment of your vol. ambulance workers' benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was such Notice delivered personally? <input type="checkbox"/> Yes <input type="checkbox"/> No or sent by Registered Mail? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, to whom was Notice delivered/sent _____ _____ Date _____			
	<small>Name of Officer and Political Subdivision</small>			

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.

I certify that copy of this was filed with \_\_\_\_\_  
Name of Officer \_\_\_\_\_ Title of Officer \_\_\_\_\_  
 \_\_\_\_\_ on \_\_\_\_\_  
Political Subdivision or Ambulance Service Liable for Benefits

Dated \_\_\_\_\_ Signed by \_\_\_\_\_ or  
Volunteer Ambulance Worker

Signed \_\_\_\_\_  
A person on his/her behalf, or in case of death, by any one or more of his/her dependents, or person on their behalf. Relationship \_\_\_\_\_ Telephone No. \_\_\_\_\_



# Limited Release of Health Information (HIPAA)

# C-3.3

State of New York - Workers' Compensation Board

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

**AUTHORIZATION TO OBTAIN INFORMATION**

**AUTHORIZATION FOR THE USE AND DISCLOSURE  
OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION**

**I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize Warren County Self-Insurance to receive may be re-disclosed and no longer protected by federal privacy regulations.**

1. Person(s) / organizations authorized to use or disclose the information:

Any medical facility that has treated me in the past.

2. Person(s) / organization to whom the requested use or disclosure may be made:

Warren County Self-Insurance and/or its agents.

3. Specific description of information that may be used or disclosed:

Copies of medical records including, but not limited to, patient questionnaires, patient intake sheets, referral forms, patient history forms, office notes, reports, charts, x-ray or other films, etc., and/or copies of hospital and medical records relating to services rendered to me for the following medical condition(s):

Any condition except those excluded below.

Excluding (1) any and all confidential HIV and AIDS related information protected under Article 27-F of the New York Public Health Law and (2) any and all confidential mental health records protected under Section 33.13 of the New York Mental Hygiene Law.

4. Purpose of the requested use or disclosure:

For the use in a pending Workers' Compensation claim brought by me.

5. I understand that I may revoke this authorization at any time by giving written notice to the person / organization that is providing the information I no longer want to be used or disclosed, except to the extent that action has already been taken in reliance on this authorization.

6. I understand that the medical provider may not condition the provision of health care services on whether I sign this authorization.

7. This authorization expires upon the final closure of the Workers' Compensation claim brought by the individual.

8. Photocopies of this authorization should be accepted as original.

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Signature of Individual Authorizing Use/Disclosure      Date      Printed Name of Individual

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For Office Use: Date of Injury: \_\_\_\_\_ Carrier Case # \_\_\_\_\_ WCB# \_\_\_\_\_



## Claimant Information Packet

### **WARREN COUNTY SELF-INSURANCE DEPARTMENT**

1340 State Route 9 \* Lake George NY 12845 \* Phone 518-761-6528 \* Fax 518-761-6249  
email [warrencountyinsurance@warrencountyny.gov](mailto:warrencountyinsurance@warrencountyny.gov)

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## **You were injured while volunteering. What now?**

If you've suffered a workplace injury or illness, you may be eligible for volunteer firefighter or ambulance worker benefits. You may have already received medical treatment. If you haven't, you should seek the medical care that is necessary.

### **A Volunteer Members' Responsibilities**

- You must tell your department or squad supervisor, in writing, when, where and how you were injured. Report injuries as soon as possible but always within 30 days of the injury.
- Medical reports are necessary for your case. Advise your doctors that you have a work-related injury, and give the name of your volunteer fire department / ambulance squad. Do not pay for your care yourself or use other health insurance. Tell your doctor to file reports with the NYS Workers' Compensation Board and with Warren County Self-Insurance, your department / squad insurance carrier. Ask that your doctor complete the "Workers' Compensation Encounter Form" and fax it back to Warren County Self-Insurance. This may help expedite your claim. If your case is disputed, the Workers' Compensation Board needs a medical report on your injury to begin resolving your claim.

### **Starting a Case**

Once your department / squad knows of your injury, they must notify the Warren County Self-Insurance Department by filing a C-2F form. You should file a Volunteer claim (VF-3 or VAW-3) form reporting your injury as soon as possible. If you injured the same body part before, or had a similar illness, you must also file a Form C-3.3. You should complete the "Authorization to Obtain Information" and give it to your department / squad supervisor immediately.

If you haven't already filed a VF-3, VAW-3 or C-3.3 (if necessary), there are three ways to do it.

- Complete the paper forms that your department / squad provided to you and give them to the supervisor. Additionally, you can also mail this form to the Workers' Compensation Board.
- Visit [www.wcb.ny.gov](http://www.wcb.ny.gov) to complete the form
- Call 1-866-396-8314. A Workers' Compensation Board employee will complete the form with you.

### **Health Care Benefits**

Do not pay your doctor or hospital. Those bills are paid by the insurer unless the Workers' Compensation Board disallows your case. If your case is disputed, the providers are paid when the Workers' Compensation Board decides your case. If the Workers' Compensation Board decides against you, or if you don't pursue a case, you will have to pay the doctor or hospital.

Warren County Self-Insurance covers medically necessary drugs and equipment that your doctor prescribes. You're also entitled to carfare or necessary expenses incurred when traveling for treatment. (Get receipts for those expenses.)

Generally, you can choose any doctor authorized by the Workers' Compensation Board. You can also use occupational health clinics. Warren County participates in the ONECALL MEDICAL diagnostic radiology network, therefore if you require diagnostic radiology services (MRI, EMG, NCS, CT, Ultrasound, Bone Scan or Arthrograms) you or your physician must contact us before performing these tests. Additionally, Warren County participates in the AWPRx pharmacy benefits network. Therefore, pharmacy benefits must be obtained from a AWPRx network pharmacy.

## **Benefits for Lost Wages**

You are entitled to a portion of your lost wages if your injury affects you in one or more ways:

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

An employer or insurer can accept your claim and begin paying your lost wage benefit promptly. Sometimes, employers and carriers dispute a claim. When that occurs, the Workers' Compensation Board strives to resolve most cases within 90 days.

You may hire an attorney or licensed representative, who can be helpful with complex or disputed claims, but it isn't required. The Workers' Compensation Board sets their fees and they will be deducted from your lost wages award. You should not pay anything directly to your attorney or licensed representative.

If your case is disputed, you may be eligible to receive short term disability benefits while the case is heard. Check with your department / squad about disability benefits and ask for a DB-450 claim form. If your case is accepted, you will pay back the disability benefits out of your lost wages award.

## **Help is Available**

People sometimes need help getting back to work. An injury can also cause family or financial problems. The Workers' Compensation Board has rehabilitation counselors and social workers to help. Call (877) 632-4996 for assistance. More information is also available on the NYS Workers' Compensation Board website at: [www.wcb.ny.gov](http://www.wcb.ny.gov)

## **What's Next?**

Warren County Self-Insurance will send you information and documentation if your claim is accepted or denied. When the claim is accepted, your treatment will be paid and lost wages benefits begin. If your case is challenged, the Workers' Compensation Board will notify you about resolving the case. If more information is necessary, the Workers' Compensation Board will contact you and tell you how to file it.

## **Important Contact Information**

Workers' Compensation Board	877-632-4996
Warren County Self-Insurance	518-761-6528

CC# \_\_\_\_\_

## Workers' Compensation Encounter Form

*To the Employee: Give one copy of this form to your physician/ chiropractor at each visit.  
(Call Self-Insurance for additional forms or duplicate this one.)*

Patient Name: \_\_\_\_\_

Date of Service: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

In your opinion, is the disability arising out of and in the course of employment or occupational disease? Yes No

Date of injury: \_\_\_\_\_

Is the patient losing time from work? Yes / No First day of lost time: \_\_\_ / \_\_\_ / \_\_\_

Can the patient return to work? Full duty / Modified duty \_\_\_ / \_\_\_ / \_\_\_

Modified duty requirements: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Prescriptions given to treat injury: \_\_\_\_\_

Treatment Plan: \_\_\_\_\_

Percentage of impairment (0-100%): \_\_\_\_\_ % Temporary / Permanent

Apportionment? Yes No Pre-existing \_\_\_\_\_ % Current injury \_\_\_\_\_ %

Next visit: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_\_ with Provider: \_\_\_\_\_

Providers Signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

**Please Fax this form immediately to: 518-761-6249**



The AWPRx pharmacy network is a national network that includes both national chains and local independent pharmacies. For a list of network pharmacies, please visit our website at [www.awprx.com](http://www.awprx.com) or call our customer service team for a list of network pharmacies in your area **888-700-0992**.

A&P	KELSEY PHARMACY	RXAMERICA
ACME PHARMACY	KERR DRUG	SAFEWAY PHARMACY
AHF PHARMACY	KING KULLEN PHARMACY	SAFFA INFUSION PHARMACY
BARTELL DRUGS	KING SOOPERS PHARMACY	SARTORIS SUPER DRUGS
BEL AIR PHARMACY	KINNEY DRUGS	SAVE MART PHARMACY
BIG Y PHARMACY	KMART PHARMACY	SAVON PHARMACY
BI-MART PHARMACY	KROGERS	SCHNUCKS PHARMACY
BROOKSHIRE BROTHERS	LONESTAR RX	SHOPKO STORE
CITY MARKET PHARMACY	LOWELL COMMUNITY HEALTH	SHOPPERS PHARMACY
COBORNS PHARMACY	CENTER PHARMACY	SHOPRITE PHARMACY
CONTINUCARE MEDICAL GROUP	MACEYS PHARMACY	SMITHS PHARMACY
COSTCO WHOLESALE	MARCS PHARMACY	ST JOHN SPECIALTY PHARMACY
CVS PHARMACY	MARSH DRUGS	STOP AND SHOP PHARMACY
DIERBERGS	MARSHFIELD CLINIC SPECIALTY	SUN MART PHARMACY
DISCOUNT DRUG MART	MARTINS PHARMACY	SUPER ONE
EMBLEMHEALTH SERVICES	MEDFAST PHARMACY	TARGET STORES
ESSENTIA HEALTH	MEIJER PHARMACY	TEXAS ONCOLOGY PHARMACY
FAGEN PHARMACY	NAVARRO HEALTH SERVICES	TFHC23 PHARMACY
FARM FRESH PHARMACY	OMNICARE	THE PHARMACY CENTER
FARMACIAS PLAZA	OSCO PHARMACY	TIMES PHARMACY
FOOD CITY PHARMACY	PARADIS SHOP N SAVE	TIMPVIEW PHARMACY
FOOD LION PHARMACY	PATHMARK PHARMACY	TOPS PHARMACY
FRUTH PHARMACY	PATIENT FIRST	UNITED MEDICAL
FRYS FOOD AND DRUG	PICK N SAVE PHARMACY	UNITED PHARMACY
GERBES PHARMACY	POSTAL PRESCRIPTION SERVICES	VANGUARD ADVANCED
GIANT EAGLE PHARMACY	PRICE CHOPPER PHARMACY	PHARMACY SYSTEMS
HAGGEN PHARMACY	PRICE CUTTER PHARMACY	VG'S PHARMACY
HARRIS TEETER PHARMACY	PUBLIX PHARMACY	VILLAGE PHARMACY
HARTIG DRUG CO INC	QFC	VILLAGE SUPERMARKETS
HARVARD VANGUARD MEDICAL	QOL MEDS	VONS PHARMACY
ASSOCIATES PHAR	QUICK CHEK PHARMACY	WALDBAUMS PHARMACY
HARVEYS SUPERMARKET	RALEYS PHARMACY	WALMART PHARMACY
HEALTHPARTNERS	RALPHS PHARMACY	WEGMANS FOOD MARKETS
HEB PHARMACY	REASORS PHARMACY	WEIS PHARMACY
HENRY FORD MEDICAL CENTER	RITE AID PHARMACY	WELLSPRING FAMILY MEDICINE
HY-VEE PHARMACY	RITZMAN PHARMACY	WHITE DRUG
	ROY HARMONS APOTHECARY	WINN DIXIE PHARMACY



## Temporary Prescription Form

Client Name: **Warren County**

### 1. Instructions for the EMPLOYER:

- Provide this form to your injured worker to have any prescription filled for a temporary **10 day supply**, and please fill out the information below:

Claimant Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
Claimant DOB: \_\_\_\_\_ Claimant's Home Phone #: \_\_\_\_\_  
Claimant Employer: \_\_\_\_\_ Date of Injury: \_\_\_\_\_  
Claimant Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Employer Representative: \_\_\_\_\_ Date: \_\_\_\_\_

### 2. Instructions for the INJURED WORKER:

- **You, the injured worker will need to bring this form and provide it to the pharmacy along with your prescriptions related to the treatment of your work related injury/illness**

### 3. Instructions for the PHARMACY:

- Please submit workers' compensation claims to **AWPRX**
- **BIN**                   **610237**
- **PCN**                   **AWPRX**
- **Group ID**           **AWPRx63**
- **ID number**           **Use Social Security from the top of the form**
- Prescription(s) will fill for a **10 Day Supply**. If there is a remaining balance on the script after the **10 Day Supply** is filled, AWPRx will call back if and when the balance has been approved. If you need assistance, please call **AWPRx** at **888-700-0922**.

AWPRx office hours are Monday through Friday, 8:00AM EST to 8:00PM EST. We also have representative's on-call 24 hours/7 days a week.

**FOR ALL REJECTIONS OR QUESTIONS CALL: (888)-700-0922**

*The Right Med. At The Right Time. At The Right Price.*

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 Warren County Self-Insurance Plan Insurer ID W874754

Name Warren County Self-Insurance Plan

Info/Attn \_\_\_\_\_

Address 1340 State Route 9

City Lake George State NY

Postal Code 12845 Country USA

Claim Admin ID W874754

**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 \_\_\_\_\_

**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 n/a \_\_\_\_\_  
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 \_\_\_\_\_