Warren County

Self-Insurance Plan Participant Handbook

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Warren County Self-Insurance Plan Contact information

Mail:

1340 State Route 9
Lake George NY 12845

Physical Location:

Warren County Human Services Building
2nd Floor

Fax:

518-761-6249

Office Email:

warrencountyinsurance@warrencountyny.gov
claims@warrencountyny.gov

Website:

www.warrencountyny.gov/insurance

Staff:

Insurance Administrator:	Amy Clute 518-761-6529 clutea@warrencountyny.gov
Deputy Insurance Administrator:	Jessica Burnham 518-824-6610 burnhamj@warrencountyny.gov
Self-Insurance Specialist:	Jennifer Smith 518-761-6528 smithj@warrencountyny.gov

General Information:

The Warren County Self-Insurance Plan is your Workers' Compensation Insurance Carrier. The Plan has the responsibility of handling and processing all aspects of claims for on-the-job injuries or occupational disease to their appropriate conclusion.

The Warren County Self-Insurance Plan is administered by the Warren County Self-Insurance Department. The Self-Insurance Department is located at the County Municipal complex in Lake George. As your carrier, the Self-Insurance Department has the dual obligation of protecting our employers from the burden of compensation liability as well as assuring each employee that he/she will receive the benefits called for by the statute.

Since you are a member of the Self-Insurance Plan, we do not provide policy numbers. Sometimes agencies will request evidence of Workers' Compensation coverage or a Certificate of Insurance. We issue SI 105.2P forms upon your request to show evidence of coverage.

There is no substitute for a sound preventative safety program to protect the interests of the employee and employer alike. All accidents have a cause and most can be prevented. However, when injuries do occur it is important to notify the Self-Insurance Department promptly. This enables the Plan to pay legitimate claims and enables the Plan to make an early thorough investigation and determination of questionable cases. This can not be done without immediate and complete cooperation from you, the employer.

All employees must be made aware of the procedures for reporting work related injuries. It is important that your employees report all injuries on the enclosed "Employee Injury Report" form.

The employee should seek the appropriate medical care if necessary. The employee may seek treatment at any provider recognized by the NYS Workers' Compensation Board. It is important that the employee inform the provider of the Self-Insurance Plan name and address for billing purposes.

If the employee misses time from work due to the injury, the Workers' Compensation Law provides that payment must be made to the employee within 18 days of the injury date, providing that the Plan has the appropriate documentation.

The person within your organization responsible for reporting injuries to the Plan shall complete the C-2F form as soon as possible after the injury. It is most important that the Plan receive the C-2F timely.

For the injuries requiring lost time from work it will be necessary for you to complete the C-240 payroll form. The instructions for this and all forms are enclosed. The Workers' Compensation rate is two thirds of the average weekly wage for the 52 weeks prior to the date of injury. (This is subject to certain maximums set by NYS statutes.)

Compensation payments are begun as long as there is medical evidence of disability. The NYS Workers' Compensation Law provides for a 7 calendar day waiting period that is not paid unless the employee is out of work for more than 14 calendar days. The Plan pays on a two-week schedule and the payments are at a "lag". Therefore, payments are never made for dates ahead of the payment date. The employee may use his/her own accrued leave time. You will need to notify the Plan if the employee is going to use accrued leave time. You will need to complete a Reimbursement Request form as soon as that employee ceases using his/her own time. (See the section on Reimbursement Requests.)

The form C-11 must be completed and sent to the Plan when the employee returns to work. This form is an overview of the time lost due to the injury.

Please remember that all original forms should be sent to:

Warren County Self-Insurance Plan
Human Services Building
1340 State Route 9
Lake George NY 12845

The forms can also be filed via fax or email prior to placing the hard copy in the regular mail.

The Plan will report to the Workers' Compensation Board so please do not submit any forms directly to the Workers' Compensation Board.

Local Law:

The Warren County Self-Insurance plan is administered per Local Law No 3 of 2014. The Local Law addresses participation, withdrawal, apportionment of costs, payments, reserves, excess insurance, safety programs, cooperation and penalties. A copy of the Local Law follows this page. Plan participants should be familiar with the Local Law provisions.

Warren County Board of Supervisors

RESOLUTION NO. 373 OF 2014

Resolution introduced by Supervisors Taylor, McDevitt, Frasier, Vanselow, Wood, Brock and Seeber

TO ENACT LOCAL LAW NO. 3 OF 2014

WHEREAS, a proposed Local Law was duly presented to the Board of Supervisors and considered by them, said proposed Local Law being entitled, "A Local Law Amending and Consolidating Local Law No. 4 of 2013 - Rules and Regulations for the Administration of the Warren County Self-Insurance Plan", and

WHEREAS, the Board of Supervisors adopted Resolution No. 317 of 2014 on June 20, 2014, authorizing a public hearing to be held by the Board of Supervisors on the 18th day of July, 2014, at 10:00 a.m. in the Supervisors' Room in the Warren County Municipal Center on the matter of the proposed Local Law, and notice of such public hearing having been duly published and posted as required by law, and said public hearing having been held and all persons appearing at said public hearing desiring to be heard, having been heard, now, therefore, be it

RESOLVED, the Board of Supervisors of the County of Warren, New York, on this 18th day of July, 2014, does hereby enact and adopt Local Law No. 3 of 2014 as set forth in Schedule "A" annexed hereto, and be it further

RESOLVED, that the Chairman of the Board of Supervisors, Clerk of the Board of Supervisors, County Administrator and County Attorney are hereby authorized to make such minor modifications to the Local Law as deemed necessary, and are authorized to execute, file and publish the Local Law and take all necessary actions for the promulgation thereof.

\tmc\ 001-14

COUNTY OF WARREN

LOCAL LAW NO. 3 OF 2014

A LOCAL LAW AMENDING AND CONSOLIDATING LOCAL LAW NO. 4 OF 2013 - RULES AND REGULATIONS FOR THE ADMINISTRATION OF THE WARREN COUNTY SELF-INSURANCE PLAN

BE IT ENACTED, by the Board of Supervisors of the County of Warren, New York as follows:

SECTION 1. Title. This Local Law shall be entitled "A Local Law Amending and Consolidating Local Law No. 4 of 2013 - Rules and Regulations for the Administration of the Warren County Self-Insurance Plan."

SECTION 2. Purpose. Pursuant to authority in Article 5 of the Workers' Compensation Law, and specifically Section 65 "Rules and regulations" thereof, and as most recently enacted through Local Law No. 4 of 2013, the purpose of this Local Law is to continue to establish rules and regulations for the fair and equitable administration and operation of the Warren County Self-Insurance Plan ("Plan"). The further purpose of this Local Law is to consolidate Local Law No. 4 of 2013 into Local Law No. 3 of 2014, and to amend Section 3.C.1. thereof "Apportionment of Costs and Payments" as provided for herein.

SECTION 3. Rules and Regulations of the Plan. The following constitute the rules and regulations for the administration of the Plan:

A. PARTICIPATION

1. In addition to the County, participation in the Plan shall be available to the city, towns, villages and fire districts in the County of Warren, the Warren County Soil & Water Conservation district, SUNY Adirondack and all volunteer fire companies and volunteer ambulance workers having their principal office in Warren County, and organized and operating in a town in Warren County currently participating in the Warren County Self-Insurance Plan; and all school districts organized and existing within Warren County and Cornell Cooperative Extension of Warren County and any public library improvement district

existing within Warren County and Civil Defense Volunteers of the Radio Amateur Civil Emergency Service and Municipal Housing Authorities which are located in Warren County and created pursuant to the public housing laws of New York State. Any of the foregoing are eligible to become a "participant" in the Plan.

B. PLAN ENTRY AND WITHDRAWAL - PAYMENT OF OUTSTANDING LIABILITIES

Any municipality or public entity eligible to participate in the Plan as set forth in paragraph "A" herein and electing to become a participant shall file a certified copy of the resolution of its governing body electing to become a participant. Membership of a participant in the Plan shall be effective upon approval of the Warren County Self-Insurance Plan Insurance Administrator ("Administrator"). Any participant may withdraw from the Plan effective January 1st by filing a written notice with the Administrator by the preceding July 1st. The notice of withdrawal from the Plan must be in the form of a certified copy of a resolution of the governing body of the participant electing to withdraw. As a condition of withdrawal from the Plan, the participant must enter into a withdrawal agreement with Warren County and must agree to pay in a lump sum or installments, an equitable share of the outstanding liabilities of the Plan as of the date of withdrawal. If payment of the equitable share of the outstanding liabilities of the Plan is to be made in installments, an installment payment plan and other necessary terms and conditions shall be set forth in the withdrawal agreement. For purposes of this paragraph, the phrase "equitable share of outstanding liabilities of the Plan" shall mean all of those current and open compensation cases originating from the participant and included in the Plan on or before the effective January 1st of the participants withdrawal from the Plan and all those compensation cases originating from the participant which are closed as of the date of withdrawal but, which in the judgment of the Administrator are likely to be re-opened after the January 1st withdrawal date. In the alternative, as a requirement of withdrawal from the Plan, the participant may

agree to transfer all existing claims to another workers' compensation administrator as approved by the New York State Workers' Compensation Board and through written agreement with Warren County. In accordance with the provisions of Workers' Compensation Law §63, in the event the withdrawing participant is a town, city or village and there is a volunteer fire department(s) or volunteer ambulance workers organized and operating within the withdrawing town, city or village who is also a participant in the Plan, the volunteer fire department(s) or volunteer ambulance workers must also withdraw from the Plan at the same time as the town, city or village withdraws from the Plan.

Upon receipt of a notice of withdrawal from a participating town, city or village as provided for herein, the Administrator shall within thirty (30) days of receipt of such notice provide written notification to each participating volunteer fire department(s) or volunteer ambulance workers operating within the town, city or village that it must withdraw from the Plan and the requirements and obligations of withdrawal as set forth herein. Payment by lump sum or in installments of the equitable share of the outstanding liability of such volunteer fire department(s) or volunteer ambulance workers organized and operating within the withdrawing town, city or village must be made in accordance with the provision set forth herein above. All withdrawal agreements shall be subject to the approval of the Warren County Board of Supervisors.

C. APPORTIONMENT OF COSTS AND PAYMENTS

1. Each participant shall be liable to pay its proportionate share of the cost of participation in the Plan, including administrative costs and expenses as determined using the following experience based formula:

Administrative expenses will be allocated among the Plan Participants in the following way.

- Volunteer Ambulance Squads (for Volunteers) collectively will be charged 7% of the total Administrative Expenses. This cost will be allocated based upon the actual number of times a squad is dispatched by the Warren County Sheriff's Department

during the last full year.

- Volunteer Fire Departments (for Volunteers) collectively will be charged 11% of the total Administrative Expenses. This cost will be allocated based upon the actual number of times a Department is dispatched by the Warren County Sheriff's Department during the last full year.
- All participants with payroll will share the balance of the Administrative Expenses (82%) based upon the participants actual gross payroll for the last full year.

Claims Expenses will be allocated among all Plan Participants based upon actual claims paid for the 8 full calendar years prior to the last January 1st. Each individual claim with a total paid for the sum of 8 years exceeding $50,000 will be charged $50,000.

D. RESERVE

1. There is hereby established for the Plan a Reserve Fund in an amount not to exceed Four Million Dollars ($4,000,000.00). Such amount shall be accumulated by including in the annual estimate of expenses a sum not to exceed Fifty Thousand Dollars ($50,000.00) and such additional amounts as the Warren County Board of Supervisors shall determine.

2. When the amount of the reserve is at the maximum, any amount expended therefrom shall be restored by including in the subsequent annual estimates a sum not to exceed Fifty Thousand Dollars ($50,000.00).

3. The Administrator may at any time at their discretion expend monies in such reserve to pay any liability of the Plan.

E. EXCESS INSURANCE

The Administrator, upon authorization by the governing committee of the Warren County Board of Supervisors, may purchase excess or catastrophe insurance in such limits as deemed appropriate, the cost thereof to be paid from the funds of the Plan.

F. SAFETY PROGRAMS

Each participant shall develop and enforce a safety program or programs designed for the reasonable and adequate protection of the lives, health and safety of employees; and shall provide for use by employees of appliances and devices designed to minimize the possibility of injury or impairment of health.

G. COOPERATION OF PARTICIPANTS

Participants in the Plan shall cooperate with the Administrator by filing all required reports, by aiding in the investigation of claims, and by developing and enforcing safety programs and by furnishing any additional aid or information that may be required to carry out the provisions of the intent of the New York State Workers' Compensation Law.

H. PENALTIES

The Warren County Board of Supervisors may by Resolution expel a participant for failure to observe the rules and regulations adopted, or for any violation of the provisions of the Workers' Compensation Law; provided, however, that a participant shall be notified in writing, at least thirty (30) days prior to the effective date of expulsion; and further provided, that expulsion shall not relieve a participant from paying its share of the outstanding liabilities of the Plan at the date of expulsion.

SECTION 4. Binding Effect. Upon the effective date of this Local Law the rules and regulations for the administration of the Plan shall be applicable to and binding upon all then existing participants in the Plan and to all future participants upon admission to the Plan.

SECTION 5. Repealer. This Local Law shall repeal, supercede or, as appropriate, consolidate into this Local Law all prior Local Laws of Warren County concerning the rules and regulations for the administration of the Plan, including Local Law No. 4 of 1981, Local Law No. 2 of 1982, Local Law No. 3 of 1982, Local Law No. 4 of 1982, Local Law No. 1 of 1989, Local Law No. 2 of 1990, Local Law No. 5 of 1992, Local Law No. 3 of 1994, Local Law No. 4 of 1994, Local Law No. 3 of 1996, Local Law No.

5 of 1996, Local Law No. 4 of 1999, Local Law No. 3 of 2000, Local Law No. 8 of 2001, Local Law No. 3 of 2009, Local Law No. 6 of 2010, Local Law No. 7 of 2010 and Local Law No. 4 of 2013. This Local Law shall not amend, repeal or supercede Warren County Local Law No. 3 of 1981 or any Local Laws amending Warren County Local Law No. 3 of 1981.

SECTION 6. Severability. If any clause, sentence, paragraph, subdivision, section or part of this Local Law or the application thereof to any person, individual, corporation, firm, partnership, entity or circumstance shall be adjudged by any court of competent jurisdiction to be invalid or unconstitutional, such order or judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part of this Local Law or in its application to the person, individual, corporation, firm, partnership entity or circumstance directly involved in the controversy in which order or judgment shall be rendered.

SECTION 7. Effective Date. This Local Law shall take effect immediately upon filing with the Secretary of State.

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Posting Notices:

The NYS Workers' Compensation Board requires the notices on the following pages be posted where you have employees. We suggest that you post these in multiple locations.

C105 is the notice of compliance for workers' compensation coverage. Complete the date the municipality joined the plan and the name of the employer before posting.

VF-105 is the notice of compliance for volunteer firefighter coverage. Complete the date the fire company joined the plan and the name of the fire company before posting.

VAW-105 is the notice of compliance for volunteer ambulance coverage. Complete the date the squad joined the plan and the name of the squad before posting.

The Pharmacy notice is ready to be copied and posted.

Public Employees Job Safety and Health Protection poster is ready to be copied and posted.

Right to Know poster must be completed and posted.

Reporting Employee Injuries poster not mandatory, but suggested posting for management areas.

Additionally, listed below are several safety program notices that are either required or suggested. These will need to be reviewed and posted by each municipality.

- Managements Statement of Commitment to Health and Safety (i.e. Safety Program Policy)
- PESH Job Safety and Health Protection Poster (aka Rights and Responsibilities poster)
- Emergency telephone numbers of managers and also medical personnel
- Right to know poster for Hazard Communication
- Exit Routes
- Room Capacities
- Floor Loadings
- Exposure to hazardous materials/substances
- Summary of work related injuries and illness (February, March & April)
- Safety Committee membership
- Safety Committee minutes
- Workplace Violence Summary
- NY Minimum Wage
- NY Unemployment Insurance NYS DOL IA 133
- Notice of Compliance for Disability Benefits if offered
- NY Voting Notice
- NY Human Rights/Discrimination
- NY Minor Hours
- Employee Access to Exposure & Medical Records

- Article 23A – Criminal Convictions
- Blood Donation Rule
- NYS Sexual Harassment Prevention Policy Notice
- EEOC Equal Employment Opportunity is the law
- Federal Minimum Wage Notice
- Employee Polygraph Protection Notice
- USERRA Rights and Benefits Notice
- Payday Notice
- IRS EITC/Notice 797/ W-4 Notice
- FMLA Family and Medical Leave Act
- NYS Paid Family Leave if offered

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

NOTICE OF COMPLIANCE

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

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

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

Customer Service Line: 877-632-4996

AVISO DE CUMPLIMIENTO

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

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

CHAIR/PRESIDENTE
Workers' Compensation Board

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

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer
Waren County Self-Insurance
1340 State Route 9
Lake George NY 12845

For Insurance Carriers ONLY: Policy No. n/a

Policy in Force from .... *to* continues

Name of employer (Nombre del patrono)

....

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

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

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD

ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

NOTICE OF COMPLIANCE VOLUNTEER FIREFIGHTERS' BENEFIT LAW

TO VOLUNTEER FIREFIGHTER

If you have disablement as a result of injury or disease incurred IN LINE OF DUTY, observe the following:

1. Report your injury promptly and, in any event, within 90 days, in writing to the home area political subdivision (county, city, town, village or fire district) on Form VF-1.
2. If you wish to claim benefits, Form VF-3, Claim for Benefits, must be filed with the same officer of the home area political subdivision with whom you filed report of injury, and with the Workers' Compensation Board within two years of injury or death. Forms VF-1, Notice of Injury or Death, and VF-3, Claim for Benefits, may be obtained from your local fire officials, home area political subdivision or the Workers' Compensation Board.
3. If you are a volunteer member of an incorporated fire company, inquire of your company officer concerning the liable political subdivision to which notice should be given and with which claim should be filed as described above.
4. Obtain medical care immediately.
5. You are entitled to be treated by a physician, psychologist (upon referral from an authorized physician), podiatrist or chiropractor of your choice if (s)he is authorized by the Chairman of the Workers' Compensation Board.
6. Tell your doctor to file medical reports with the Board and with the liable political subdivision or its insurance carrier.
7. **DO NOT pay your doctor or hospital.** Their bills will be paid by the liable political subdivision or its insurance carrier if your case is not disputed. If your case is disputed, the doctor 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.**
8. You are not required to have anyone represent you in any workers' compensation proceeding, but you have the right to be represented by an attorney or licensed representative, if you so choose. **If you obtain representation, do not pay your attorney or representative directly.** When the Workers' Compensation Board rules on your case, the attorney's or representative's fee will be set by the Board and the amount will be deducted from your award.
9. If you have difficulty in obtaining Forms VF-1 or VF-3 or need help in filling them out, or if you have any other questions or problems about an injury or disease incurred in the line of duty, contact the Workers' Compensation Board.

REQUISITOS EXIGIDOS POR LA LEY DE BENEFICIOS PARA LOS BOMBEROS VOLUNTARIOS

A LOS BOMBEROS VOLUNTARIOS

Si resultas incapacitado como resultado de lesión o enfermedad ocurrida en el EJERCICIO DE TUS FUNCIONES, cumple con los siguiente requisitos:

1. Informe de su condición inmediatamente por escrito a la entidad gubernamental donde esté localizada su residencia (condado, ciudad, pueblo, o estación de bomberos) en la forma VF-1. Hay un término límite de 90 dias.
2. Si interesa reclamar beneficios, debe llenar la forma VF-3 (Claim for Benefits) y presentarla al mismo funcionario a quien le presentó la forma VF-1. Tambien deberá notificarse a la Junta de Compensación Obrera dentro del término de dos años de ocurrida la lesión o muerte. Todas estas formas pueden conseguirse en su oficina de bomberos, entidades gubernamentales cercanas a su residencia o en la Junta de Compensación Obrera.
3. Si usted es un bombero voluntario de una compañia independiente, preguntele a los oficiales sobre a que entidad gubernamental y con cual forma se le debe notificar lesiones o enfermedad.
4. Obtenga atención médica inmediatamente.
5. Usted tiene derecho a ser atendido por un médico, psicologo (cuando es referido por un médico autorizado), podiatra o quiropráctico que usted seleccione para ser tratado de una lesión o enfermedad, siempre y cuando la persona que provea el servicio esté validado por el Presidente de la Junta de Compensación Obrera.
6. Digale a su doctor que presente los informes médicos a la Junta, la entidad gubernamental o a su compañia de seguros.
7. **NO PAGUE ni al médico ni al hospital.** Sus facturas seran pagadas directamente si su caso no es impugnado. Si lo es, el médico tendrá que esperar hasta que la Junta decida el caso. **Si usted no procede con su caso ó si la Junta decide en su contra, entonces usted tendrá que pagar al médico y al hospital.**
8. Aunque no es obligatorio, usted tiene el derecho de estar representado legalmente o por representante autorizado. **No pague por ese servicio.** Cuando el caso se decida la Junta determinará la tarifa que se la pagará al abogado/a o al representante autorizado y la misma será descontada de su compensación.
9. Si usted tiene dificultad en obtener los formularios o tiene dudas o necesita ayuda para llenarlos comuniquese con la oficina mas cercana de la Junta de Compensación Obrera.

KENNETH J. MUNNELLY, Chair/Presidente

The undersigned political subdivision hereby gives notice that it has complied with all the rules and regulations of the Chair and the Workers' Compensation Board pursuant to the Volunteer Firefighters' Benefit Law, and that it has secured the payment of benefits to its volunteer firefighters when engaged in fire fighting duties enumerated in or brought within the provisions of said law and the dependents of volunteer firefighters in accordance with the Volunteer Firefighters' Benefit Law by: (insert words "Insurance Policy" or "Self-Insurance")

Insert name, address and telephone number of county self insurance plan
Warren County SIF, 1340 State Route 9, Lake George NY 12845
518-761-6528

Effective From ____________ To *continues*
(Efectivo de) (a)

Policy No. *n/a*
(Poliza Num.)

Name of political subdivision in full: (Nombre completo de la entidad gubernamental:)

By________________________________

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

LA JUNTA DE COMPENSACION OBRERA EMPLEA Y SIRVE A PERSONAS CON IMPEDIMENTOS SIN DISCRIMINAR.

VF-105 (9-16) Prescribed by Chairman Workers' Compensation Board

THIS NOTICE MUST BE POSTED AND MAINTAINED IN A CONSPICUOUS PLACE IN AND ABOUT THE FIREHOUSE AND FIRE COMPANY HEADQUARTERS, AND SHOULD ALSO BE POSTED AT EACH PRINCIPAL ENTRANCE USED BY VOLUNTEER FIREFIGHTERS.

NYS Workers' Compensation Board, Centralized Mailing, PO Box 5205, Binghamton, NY 13902-5205
Customer Service Toll-Free Line: 877-632-4996

www.wcb.ny.gov
Statewide Fax Line: 877-533-0337

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD

ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

NOTICE OF COMPLIANCE VOLUNTEER AMBULANCE WORKERS' BENEFIT LAW

TO VOLUNTEER AMBULANCE WORKER

If you have disablement as a result of injury or disease incurred IN LINE OF DUTY, observe the following:

1. Report your injury promptly and, in any event, within 90 days, in writing to the home area political subdivision (county, city, town, village or ambulance district) or unaffiliated ambulance service on Form VAW-1.
2. If you wish to claim benefits, Form VAW-3, Claim for Benefits, must be filed with the same officer of the home area political subdivision or ambulance service with whom you filed report of injury, and with the Workers' Compensation Board within two years of injury or death. Forms VAW-1, Notice of Injury or Death, and VAW-3, Claim for Benefits, may be obtained from your local ambulance officials, home area political subdivision or the Workers' Compensation Board.
3. Obtain medical care immediately.
4. You are entitled to be treated by a physician, psychologist (upon referral from an authorized physician), podiatrist or chiropractor of your choice if (s)he is authorized by the Chairman of the Workers' Compensation Board.
5. Tell your doctor to file medical reports with the Board and with the liable political subdivision, the liable ambulance service, or its insurance carrier.
6. **DO NOT pay your doctor or hospital.** Their bills will be paid by the liable political subdivision, the liable ambulance service, or its insurance carrier if your case is not disputed. If your case is disputed, the doctor 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.**
7. You are not required to have anyone represent you in any workers' compensation proceeding, but you have the right to be represented by an attorney or licensed representative, if you so choose. **If you obtain representation, do not pay your attorney or representative directly.** When the Workers' Compensation Board rules on your case, the attorney's or representative's fee will be set by the Board and the amount will be deducted from your award.
8. If you have difficulty in obtaining Forms VAW-1 or VAW-3 or need help in filling them out, or if you have any other questions or problems about an injury or disease incurred in the line of duty, contact the Workers' Compensation Board at phone number listed below.

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5202

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

AVISO DE CUMPLIMIENTO DE LA LEY DE BENEFICIOS PARA VOLUNTARIOS DE LOS CUERPOS DE AMBULANCIAS

AL VOLUNTARIO DE UN CUERPO DE AMBULANCIAS

Si resulta incapacitado como resultado de lesiones o enfermedades incurridas en el CUMPLIMIENTO DE SU DEBER, proceda de la forma siguiente:

1. Informe de su lesión o lesiones lo antes posible, y de todos modos en el plazo de 90 dias, por escrito, a la subdivisión politica donde esté enclavado su domicilio (condado, ciudad, pueblo, o distrito de ambulancias) o el servicio de ambulancias no afiliado, utilizando el formulario VAW-1.
2. Si piensa usted reclamar beneficios, debe llenar el formulario VAW-3 (Claim for Benefits) y presentario al mismo funcionario de la subdivisión politica en que está enclavado su domicilio o el servicio de ambulancias, a quien presentó usted el informe de lesión o lesiones, y también a la Junta de Compensación Obrera, en el plazo de dos años desde la fecha de la lesión o muerte. Los formularios VAW-1 (Notice of Injury) y VAW-3 (Claim for Benefits) se puede obtener de los directivos de su cuerpo de ambulancias local, de la subdivisión politica en que está enclavado su domicilio, o de la Junta de Compensación Obrera.
3. Obtenga inmediatamente atención médica.
4. Usted tiene derecho a ser atendido por un médico, psicologo (cuando es referido por un médico autorizado), podiatra o quiropráctico que usted seleccione, siempre y cuando la persona que provea el servicio esté validado por el Presidente de la Junta de Compensación Obrera.
5. Digale a su doctor que presente los informes médicos a la Junta y a la subdivisión politica responsable, el servicio de ambulancias responsable, o el asegurador.
6. **NO PAGUE ni al médico ni al hospital.** Las facturas respectivas serán pagadas por la subdivisión politica responsable, el servicio de ambulancias responsable, o el asegurador de éste, si su caso no es impugnado. Si es impugnado, el médico tendrá que esperar para que se le pague hasta que la Junta decida el caso. **Si no plantea usted demanda o si la Junta decide en contra suya, tendrá que pagar al médico y al hospital.**
7. No se le exige a usted tener a alguien que lo/la represente en ninguno de los trámites de compensación obrera; sin embargo, usted tiene el derecho de ser representado/a por un/a abogado/a o un representante licenciado si prefiere esto. **En caso de obtener usted representación, no pague directamente al abogado/a o representante.** Cuando la Junta de Compensación decida en el caso de usted, los honorarios de abogado/a o de representante serán fijados por la Junta y serán deducidos de los beneficios que se le den a usted.
8. Si tiene usted dificultad en obtener los formularios VAW-1 y VAW-3, o si necesita ayuda para llenarios, o tiene usted cualquier otra pregunta o problema con respecto a la lesión o lesiones o enfermedades incurridas en el cumplimiento de su deber, comuniquese con una oficina cualquiera de la Junta de Compensación Obrera.

KENNETH J. MUNNELLY, Chair/Presidente

The undersigned hereby gives notice that it has complied with all the rules and regulations of the Chair and the Workers' Compensation Board pursuant to the Volunteer Ambulance Workers' Benefit Law, and that it has secured the payment of benefits to its volunteer ambulance workers when engaged in duties enumerated in or brought within the provisions of said law and the dependents of volunteer ambulance workers in accordance with the Volunteer Ambulance Workers' Benefit Law by: (insert words "Insurance Policy" or "Self-Insurance")

Insert name, address and telephone number of insurance company, county self insurance plan or main office of self insurer.

Warren County SIF, 1340 State Route 9, Lake George NY 12845 518-761-6528

Effective (*En Vigor*) From ____________ To (*Hasta*) continues

Policy No. (*Poliza No.*) n/a

Name of political subdivision or unaffiliated volunteer ambulance service in full: (Nombre completo de la subdivisión politica o servicio no afiliado de voluntarios de cuerpos de ambulancias:

By______________________________

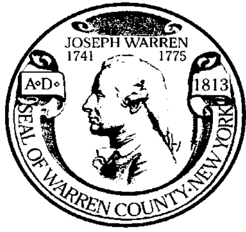
THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

LA JUNTA DE COMPENSACION OBRERA EMPLEA Y SIRVE A PERSONAS CON IMPEDIMENTOS SIN DISCRIMINAR.

VAW-105 (9-16)

Prescribed by Chairman Workers' Compensation Board, State of New York

THIS NOTICE MUST BE POSTED AND MAINTAINED IN A CONSPICUOUS PLACE IN AND ABOUT THE AMBULANCE COMPANY HEADQUARTERS AND SHOULD ALSO BE POSTED AT EACH PRINCIPAL ENTRANCE USED BY VOLUNTEER AMBULANCE WORKERS.



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

NOTIFICATION CONCERNING WORKERS' COMPENSATION PHARMACY BENEFITS

Please read this notice carefully. It provides you with important information on getting medication related to a workers' compensation claim.

As of October 1, 2015, the Warren County Self-Insurance Fund has entered into an agreement with **AWPRx** to make available the medications workers may receive for their work-related injury or illness. This does not change your right to get the medication necessary to treat such an illness or injury. <u>It only means that you must obtain that medication from pharmacies identified by AWPRx.</u>

If you are obtaining your medication through a workers' compensation claim, you need to obtain that medication from one of these pharmacies unless:

- You have a medical emergency and it is not reasonably possible to purchase the medications you need for that emergency.
- Ordering by mail or telephone is not an option in the network, no pharmacy in the network will deliver to you, and none of these pharmacies is within ten miles if you live in a rural area, or one mile if not. If you believe this is the case for you, please call one of the numbers on the bottom of this page.

All pharmacies are required to keep a sufficient stock of medication on hand so that they can service you without undue delay.

All in-store pharmacies must be open for business during hours that are typical in your community, and must post a sign saying that they serve injured workers who receive their benefits from Warren County Self-Insurance.

These pharmacies will directly bill Warren County SIF so you will not have to pay out of pocket.

You may obtain additional information about the pharmacies from the toll free 24 hour telephone number: 888-700-0992
If you have any questions or problems, please call Warren County SIF at 518-761-6528 or the Workers' Compensation Board at 1-877-632-4996 or the Board's Advocate for Injured Workers at 800-580-6665, or you can find further information on the web at www.wcb.ny.gov.

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 or call our customer service team for a list of network pharmacies in your area **888-700-0992**.

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

Labor Law Information Relating to

Public Employee Safety and Health

Public Employees Job Safety & Health Protection

The New York State Public Employee Safety and Health Act of 1980 provides job safety and health protection for workers through the promotion of safe and healthful working conditions throughout the State. Requirements of the Act include the following:

Employers

Employers must provide employees with a workplace that is:

- free from recognized hazards,
- in compliance with the safety and health standards that apply to the workplace, and
- in compliance with any other regulations issued under the PESH Act by the Commissioner of Labor.

Employees

Employees must comply with all safety and health standards that apply to their actions on the job. Employees must also comply with any regulations issued under the PESH Act that apply to their job.

Enforcement

The New York State Department of Labor administers and enforces the PESH Act. The Commissioner of Labor issues safety and health standards. The Department's Division of Safety and Health (DOSH) has Inspectors and Hygienists who inspect workplaces to make sure they are following the PESH Act.

Inspection

When DOSH staff inspect a workplace, a representative of the employer and a representative approved by the employees must be allowed to help with the inspection. When there is no employee-approved representative, DOSH staff must speak with a fair number of employees about the safety and health conditions in the workplace.

Order to Comply

If the Department believes an employer has violated the PESH Act, we will issue an order to comply notice to the employer. The order will list dates by which each violation must be fixed. If violations are not fixed by those dates, the employer may be fined.

The order to comply must be posted at or near the place of violation, where it can be easily seen. This is to warn employees that a danger may exist.

Complaint

Any interested person may file a complaint if they believe there are unsafe or unhealthful conditions in a public workplace. This includes:

- An employee
- A representative of an employee
- Groups of employees
- A representative of a group of employees

Make this complaint in writing to the nearest DOSH office or by email to: Ask.SHNYPESH@labor.ny.gov. On request, DOSH will not release the names of any employees who file a complaint. The Department of Labor will evaluate each complaint. The Department will notify the person who made the complaint of the results of the investigation.

These complaints may also be made to the United States Department of Labor, Occupational Safety and Health Administration online at: www.osha.gov.

Discrimination

Employees may not be fired or discriminated against in any way for filing safety and health complaints or otherwise exercising their rights under the Act.

If an employee believes that they have been discriminated against, he or she may file a complaint with the nearest DOSH office. File this complaint within 30 days of the discrimination incident.

Voluntary Activity

The Department of Labor encourages employers and employees to voluntarily:

- reduce workplace hazards, and
- develop and improve safety and health programs in all workplaces.

The Division of Safety and Health can provide free help with identifying and correcting job site hazards. Employers may request this assistance on a voluntary basis by emailing: Ask.SHNYPESH@labor.ny.gov.

Additional information may be obtained from the nearest DOSH District Office below:

Albany District
State Office Campus
Bldg. 12, Rm. 158
Albany, NY 12240
Tel: (518) 457-5508

Binghamton District
44 Hawley St., Rm. 901
Binghamton, NY 13901
Tel: (607) 721-8211

Buffalo District
65 Court Street
Buffalo, NY 14202
Tel: (716) 847-7133

Garden City District
400 Oak Street
Garden City, NY 11550
Tel: (516) 228-3970

New York City District
75 Varick St., 7th Floor
New York, NY 10013
Tel: (212) 775-3554

Rochester District
109 S. Union St., Rm. 402
Rochester, NY 14607
Tel: (585) 258-8806

Syracuse District
450 South Salina Street
Syracuse, NY 13202
Tel: (315) 479-3212

Utica District
207 Genesee Street
Utica, NY 13501
Tel: (315) 793-2258

White Plains District
120 Bloomingdale Road
White Plains, NY 10605
Tel: (914) 997-9514

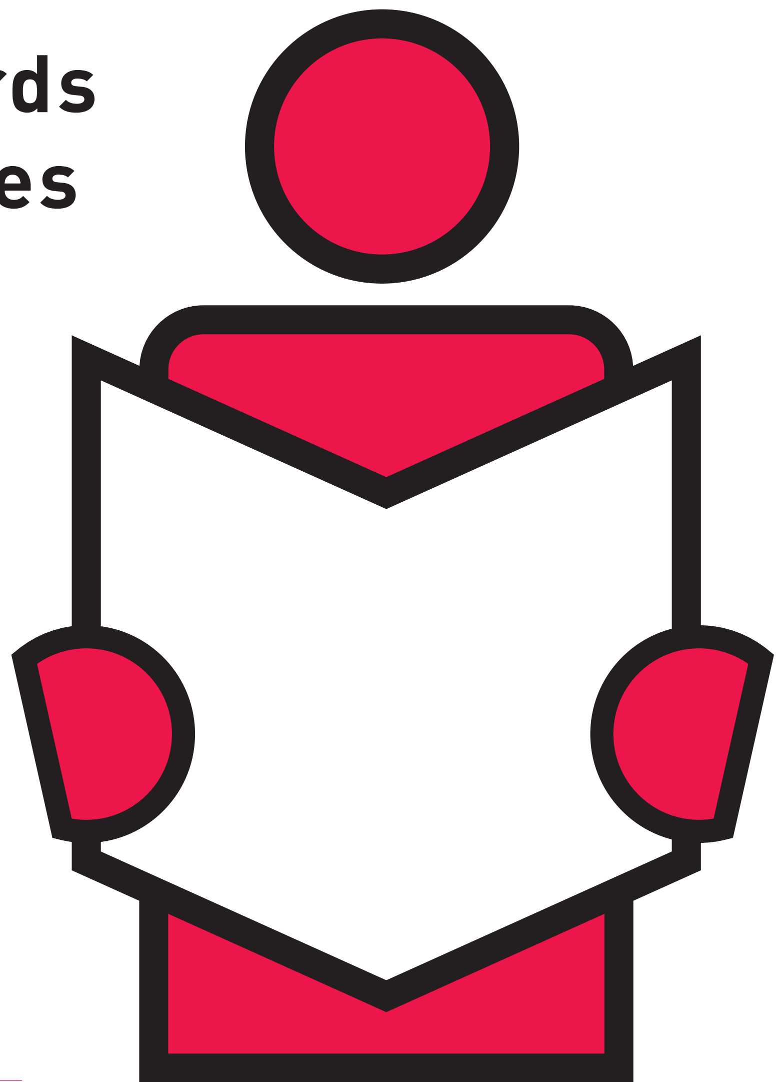
Post Conspicuously

A Division of the New York State Department of Labor

P208 (7/17) The New York State Department of Labor is an Equal Opportunity Employer/Program. Auxiliary aids and services are available upon request to individuals with disabilities.

YOU HAVE A RIGHT TO KNOW!

Your employer must inform you of the health effects and hazards of toxic substances at your worksite.



Learn all you can about toxic substances on your job.

For more information, contact:

Name

Location & Phone Number

THE RIGHT TO KNOW LAW WORKS FOR YOU.

NEW YORK STATE DEPARTMENT OF HEALTH

REPORTING EMPLOYEE INJURIES

Injuries requiring emergency room care

and/or

time away from work beyond the day of the injury

REPORT to Warren County Self-Insurance as soon as possible

e/m: warrencountyinsurance@warrencountyny.gov

phone: 518-761-6528, 518-761-6529, 518-824-6610

Provide employee name, phone number, & a brief description of injury

(Follow with the claim documentation paperwork)

REPORT TO NYS DOL PESH:

Within 8 hours:

workplace death of employee or

hospitalization of 2 or more employees

NYS DOL PESH Phone: 518- 457-5508

Safety Program and Risk Management:

As a public employer do you know?

- ✓ All places of employment are required to have an emergency action plan and all public sector employees need annual training on the emergency plan.
- ✓ All public sector employees must have annual training on the hazardous substances in their workplaces and you must have a "right to know" policy and maintain an employee accessible file for Safety Data Sheets.
- ✓ All public employers must develop, implement, follow, notify, report and continuously update your Workplace Violence Plan as well as provide training to employees.
- ✓ All public employers must assess the Personal Protective Equipment (PPE) needs for each job an employee is asked to do. Additionally the employer must inspect and approve for use any PPE an employee provides for themselves. Employers must provide training in the proper use of PPE and enforce its use.
- ✓ All public employers must report injuries and illness on the prescribed PESH reporting forms and maintain a log of injuries during the year.
- ✓ Municipalities should have a written risk management policy and risk management committee.
- ✓ Municipalities should have a designated person that is responsible for the day to day risk management activities.

Additionally, Warren County Local Law (#3 of 2014) that governs the Self-Insurance Plan states that "each participant shall develop and enforce a safety program or programs designed for the reasonable and adequate protection of the lives, health and safety of employees; and shall provide for use by employees of appliances and devices designed to minimize the possibility of injury or impairment of health." It is imperative that each participant actively participate in safety awareness, training, and education. All accidents are preventable, accidents don't just happen. We will discuss how your premiums are calculated later in this manual. However, you should be aware that premiums are based on claims experience. Therefore, it is to your advantage to reduce accidents and therefore reduce claims and costs.

Warren County Self-Insurance has contracted with a local safety consultant, Needham Risk Management Resources Group to assist plan participants with their safety program development, maintenance and training. Please contact Self-Insurance for more information about the services provided by the safety consultant. In addition to the Safety Consultant there are many resources available for safety and health programs. The New York State Department of Labor, Public Employees Safety and Health bureau is a tremendous resource. Most of you are aware of PESH and the consequences for not abiding by their regulations and standards. However, PESH also has a consultation service that is available to you. The consultant will visit your location and make recommendations on making your facility a safer place to work. You must request this service directly from PESH. Additionally, your property and liability insurance carrier can often assist with safety and health training.

Below are several helpful websites:

OHSA:	www.osha.gov
American Society of Safety Engineers:	www.asse.org
National Safety Council:	www.nsc.org
American National Standards Institute:	www.ansi.org
American Industrial Hygiene Assoc.:	www.aiha.org
Center for Disease Control & Prevention:	www.cdc.gov
US Dept of Transportation:	www.dot.gov
NYS Dept of Labor (PESH):	www.dol.ny.gov
(hover over workforce protections and then click on	safety and health)
Risk Management Magazine:	www.rmmagazine.com
NY Self-Insurers Association:	www.nyselfinsurance.com
Federal Emergency Management Agency:	www.fema.gov
NY Self-Insured Counties:	www.nysasic.org
Empire State Safety Association	www.empirestatesafety.com

It is also important to be aware of the PESH standards and the training and education that is required. PESH standards govern Public Employers in New York State. Many PESH standards mirror the OSHA standard and often the Code of Federal Regulations section 1910 can be a guide for you. However, be aware that sometimes PESH standards are stricter than the OSHA standard.

Always be aware that any safety and health program needs constant review and revision. It is very important to make sure your program is adequate and performing at the level that you expect.

Accident Reporting:

The first step to accident reporting is to educate your employees about the reporting procedures. This should occur for all current employees and also for any new employees. This is a requirement of PESH.

When training employees they should be advised to report injuries as soon as possible to their supervisor. We have developed an injury packet with forms to be used by both the employee and the supervisor to properly report claims. The attached packet should be used for municipal employees, volunteer firefighters and volunteer ambulance workers.

At the time an employee states that they were injured at work, **if they are seeking medical care or will miss time from work,** the employee should be given the packet of forms "Work Related Injury Report Procedure". The forms contain instructions for completion and advise the injured worker to immediately return them to their supervisor. Always report any accident regardless of how minor to the Plan. Section 110 of the Workers' Compensation Law defines reporting procedures. Section 110 states that reports shall be filed within ten days after the occurrence of the accident. However, we strongly encourage reporting much more timely. The Employee must provide written notice to the Employer within 30 days after the accident causing injury. In the event that an employee is seriously injured (transport to hospital or out of work more than the day of injury) we ask that you immediately call Self-Insurance and provide the employees name, brief injury description and employees home phone number.

If the employee does not plan to seek medical treatment or miss time from work, the incident can be recorded on the "Incident Tracking Log" and kept on file. The Incident Tracking Log is for incidents that are not severe. If the employee's injury becomes severe enough to seek medical treatment or miss time from work, then the forms in the "Work Related Injury Report Procedure" must be completed and a copy of the appropriate page from the Incident Tracking Log should be forwarded to Self-Insurance with the injury report forms. NOTE: it is advisable to make contact with the employee about a week after the incident to verify that the status of the incident has not changed. If the employee has sought medical care this is the time to do the injury forms packet. It's also a good time to remind the employee to let you know if they do seek medical treatment in the future.

Please make sure all forms are complete and signed. The Plan will return any forms not properly completed.

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

Enter the name of the injured employee at the top of the report. Fill out the Date of Injury/Illness, to the best of your knowledge. If you do not have or know the Workers' Compensation Board Case Number or Claim Administrator Claim Number, please leave the corresponding field blank. It is not required to process the form.

Insurer / Claim Administrator Information:
- **Insurer Name** –Warren County Self-Insurance Plan.
- **Insurer ID** –W874754
- **Name** – Warren County Self-Insurance Plan
- **Info/Attn** –blank
- **Address, City, State, Postal Code, & Country** – 1340 State Route 9, Lake George NY 12845, USA
- **Claim Admin ID** –W874754

Employee Information:
- **First Name, Middle Initial, Last Name, Suffix** – the injured employee's full legal name.
- **Mailing Address, City, State, Postal Code, & Country** – the full address of the injured employee.

• **Phone Number** – the employee's phone number including area code.
• **Date of Hire** - the date the employee was hired.
• **Date of Birth** – the employee's date of birth.
• **Gender** – check the appropriate gender.
• **Employee SSN** – the employee's Social Security Number (SSN).
• **Occupation Description** – identify employee's primary occupation at the time of accident

Claim Information:
• **Time of Injury** – the time when the injury/illness occurred.
• **Date Employer Had Knowledge of the Injury** – the date the employer had knowledge of the injury/illness.
• **Employment Status** – the applicable employment status for the employee (i.e. full time, part time, seasonal, volunteer, etc.).
• **Date Employer Had Knowledge of Date of Disability** – the date the employer was notified or became aware of employee's work related disability/incapacity.
• **Estimated Weekly Wage** – enter the employee's average weekly gross pay before the injury/illness.
• **Number of Days Worked Per Week** – enter the number of regularly scheduled workdays per week (1-7).

Employee Injury:
• **Full Wages Paid for Date of Injury** – check *Yes* or *No*.
• **Employer Paid Salary in Lieu of Compensation** – check *Yes* or *No* to indicate if the employee continued to receive pay after the illness/injury, such as sick leave or disability pay.
• **Initial Treatment** – check the initial treatment type.
• **Death Result of Injury** – check *Yes*, *No* or *Unknown* to indicate if the injury/illness resulted in death.
• **Date of Death** – indicate the date of death, if applicable.
• **Number of Dependents** – the number of dependents, *if known (for death cases only).*
• **Natures of Injury -** indicate the type of injury (i.e. Laceration, Burns, Fracture, Strain, etc.).
• **Part of Body** – indicate the part of body that was injured (i.e. left arm, right foot, head, multiple, etc.).
• **Causes of Injury -** indicate what caused the injury (i.e. Motor Vehicle, Machine, Strain or Injury by lifting, etc.).
• **Accident/Injury Description** – describe how the accident occurred and the resulting injuries.

Work Status:
• **Initial Date Last Day Worked** – the last day worked prior to lost time.
• **Return to Work Type** – check *Actual* for employee actually returned to work, or check *Released* for employee was released to work but did not do so.
• **Initial Date Disability Began** – first day of disability (lost time)
• **Physical Restrictions** – check *Yes* if the employee has returned to work with restrictions; check *No* if the employee has returned to work without restrictions.
• **Initial Return to Work Date** – if the employee has returned to work, indicate the initial return to work date.
• **Return to Work Same Employer** – check *Yes* or *No*.

Accident Location and Witnesses:
• **Premises** – check appropriate location where injury occurred. *Employer*-accident occurred on employer's premises; *Lessee*-accident occurred on the premises of the lessee for which the employee was hired to work; or *Other*-accident occurred at a location other than the employer for which the employee was hired to work. Check *Employer*, if employee was a member of a Volunteer Ambulance Service or a Volunteer Fire Department and was injured while working for his/her own service/department. Check *Other,* if the employee was injured working in an official capacity for a Volunteer Ambulance Service or Volunteer Fire Department other than the one he/she was a member of.
• **Organization Name** – the name of the organization where the injury/illness occurred.
• **Street, City, State, Postal Code, County, & Country** – the address where the injury/illness occurred.
• **Location Narrative** – provide any additional description of the location (i.e. Building C, 4th Floor in Room 101).
• **Witnesses & Business Phone Number** – indicate the names and business phone numbers of any witnesses to the injury/illness.

Employer Information:
• **Name** – the name of the company or the owner's name and DBA name.
• **Employer FEIN** – your Federal Employer Identification Number (FEIN). This is your Federal Tax ID number. If you do not have a FEIN, enter your Social Security Number.
• **UI Number** – enter the first 7 digits of your New York Unemployment Insurance (NY UI) Registration Number (UIER). This is the number used to report to the Department of Labor.
• **Manual Classification Code** – the New York Compensation Insurance Rating Board (NYCIRB) manual classification code, if known.

• **Industry Code** – the North American Industry Classification System (NAICS). If you do not know your NAICS, please describe the type or nature of business as accurately as possible (e.g., Restaurant, Construction, Retail).
• **Info/Attn** – indicate any additional pertinent contact information for the employer.
• **Mailing Address, City, State, Postal Code,& Country** – the employer's main address where you receive mail (such as a central office). Include P.O. Boxes.
• **Physical Address, City, State, Postal Code, & Country** – the physical address of the employer (if different).
• **Supervisor Name** & **Supervisor Business Phone Number** – indicate the name and phone number for the employee's direct supervisor, including area code.

Insured Information:
• **Insured Name** – the name of the insured entity. If the employee was a member of a Volunteer Ambulance Service or a Volunteer Fire Department, the name of the ambulance service or fire department should be entered.
• **Insured FEIN** – the Insured's Federal Employer Identification Number (FEIN). This is your Federal Tax ID number. If you do not have a FEIN, enter your Social Security Number. If the insured is a Volunteer Ambulance Service or Volunteer Fire Department the FEIN of the ambulance service or fire department should be entered.
• **Insured Location ID** – indicate the Insured Location ID, if any (i.e. Store 202, Jobsite 51, etc.).
• **Insured Type** – check the insurance arrangement: *Insured*, *Self-Insured*, or *Uninsured*.
• **Policy Number ID** – your Workers' Compensation Insurance Policy Number.
• **Policy Effective** & **Expiration Date** – the policy effective and expiration dates.

Please be sure to sign the form at the bottom of Page 3. Unsigned forms will be promptly returned.

Forms are also available on our website at http://www.warrencountyny.gov/insurance/.

Updated 4-2420ac

Warren County Self-Insurance

INCIDENT TRACKING LOG

Use this form to record employee incidents that happened while at work but did not result in any lost time or any medical treatment. If in the future the employee seeks medical treatment or misses work the proper forms for reporting a workplace injury must be completed.

Municipality:_________________________________

Department:______________________________________ For the year:______________

Employee Name:____________________________________ Date and Time of Incident:__________________

Nature of injury (if any):____

What was the employee doing when the incident occurred:____

What happened to injure or nearly injure the employee:____

Is this incident related to work?________________ Supervisor of employee:___________________________

Person Completing this form:_____________________________________Date:________________________

Employee Name:____________________________________ Date and Time of Incident:__________________

Nature of injury (if any):____

What was the employee doing when the incident occurred:____

What happened to injure or nearly injure the employee:____

Is this incident related to work?________________ Supervisor of employee:___________________________

Person Completing this form:_____________________________________Date:________________________

Employee Name:____________________________________ Date and Time of Incident:__________________

Nature of injury (if any):____

What was the employee doing when the incident occurred:____

What happened to injure or nearly injure the employee:____

Is this incident related to work?________________ Supervisor of employee:___________________________

Person Completing this form:_____________________________________Date:________________________

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

Work Related Injury Report Procedure

Warren County Department of SOCIAL SERVICES

This packet should be provided to any employee that sustains a work related injury requiring medical care or time off from work. If there is no medical care or time off from work, record the incident on a separate incident only form.

Employee Responsibilities:

1. Complete "Employee Injury Report"
2. Complete "Authorization to Obtain Information"

   Give the 2 forms above to your supervisor immediately.

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

   a. Take a copy of "Workers' Compensation Medical Visit Encounter Form" with you to each doctor visit.

   b. Ask your medical providers to send all bills to Warren County Self-Insurance, 1340 State Route 9, Lake George NY 12845. Be sure to mark the date of injury clearly on all correspondence.

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

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

Supervisor Responsibilities:

1. If the injury is serious or the employee is expected to be out of work more than one (1) day, call Self-Insurance immediately to alert them to the claim. Follow up with the paper work as soon as possible.
2. Confirm that the employee has completed and given you the forms:

   "Employee Injury Report"

   "Authorization to Obtain Information"

3. Advise and confirm that the employee has retained forms:

   "Claimant Information Packet"

   "Workers' Compensation Medical Visit Encounter Form"

   The list of pharmacies

4. Complete the Employer Instructions section on the "Temporary Prescription Form" page and return that page to the employee.
5. Investigate the incident to determine the root cause. Complete the "Supervisors Report of Incident Investigation."
6. If there were witness(es) to the accident, obtain statements from each one about the incident.
7. Forward completed Employee forms (2), completed Supervisors form (1) and any witness statements to the Commissioner of Social Services as soon as possible. Timely filing is very important to avoid penalties.
8. Commissioner of Social Services will complete the C2-f and forward all forms to Self-Insurance.
9. Notify Self-Insurance when employee returns to work OR if the employee's condition changes.

EMPLOYEE INJURY REPORT

This form should be completed by any employee that has sustained a work related injury and is seeking medical treatment or will miss time from work due to injury.

PLEASE PRINT CLEARLY

Employee Name:_____________________________________ Date of Birth: ________________Phone:______________

Employee Address:____

Last 4 digits of Social Security #: xxx-xx-_________ What municipality do you work for?___________________________

DATE OF INJURY: ________________Time of injury: _______am pm Time you began work that day: ________am pm

Where were you working when the injury happened?

What were you doing when you got injured and how did the injury happen?

Explain fully the nature of your injury; list body parts affected and if right or left:

Are you going to seek medical attention for this injury? _____ If so, where? ____________________________________

Are you out of work due to this injury? ________ If so, what date did you stop working?____________________

When do you expect to return to work?_____________________

How could this incident have been prevented?

Did anyone witness the injury?______

If so, please list names:____

Have you ever injured the same body part before, at work or at home?______ If so, give details below:

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.

Employees Signature:____Date:____________________

Please give this form to your immediate supervisor as soon as possible.

Employee Injury Report 3-2020

AUTHORIZATION TO OBTAIN INFORMATION

AUTHORIZATION FOR THE USE AND DISCLOSURE
OF INDIVIDUALLY INDENTIFIABLE 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 Section33.13 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.

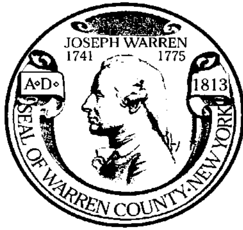
6. I understand that the medical provider may not condition the provision of health care services on whether I sign this authorization.

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

8. Photocopies and electronic copies of this authorization should be accepted as original.

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

For Office Use: Date of Injury:______________ Carrier Case #______________ WCB#______________



<u>Claimant Information Packet</u>

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

You were injured at work. What now?

If you've 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 the medical care that is necessary.

A Worker's Responsibilities

- You must tell your employer, 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 employer. <u>Do not pay</u> 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 employer's insurance carrier. Ask that your doctor complete the "Workers' Compensation Medical Visit 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 employer knows of your injury, they must notify the Warren County Self-Insurance Department by filing a C-2f form. You should file an "Employee Injury Report" form reporting your injury as soon as possible. You should complete the "Authorization to Obtain Information" and give it to your employer immediately.

Additionally, you may file a C-3 Employee Claim with the NYS Workers' Compensation Board, there are two ways to do it.

- Visit <u>www.wcb.ny.gov</u> to complete the form
- Call 1-877-632-4996. A Workers' Compensation Board employee will assist 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. Make sure that you obtain receipts for those expenses, and submit them to Warren County Self-Insurance on a Claimants Record of Medical and Travel Expenses and request for Reimbursement (Form C257).

Generally, you can choose any health care provider authorized by the Workers' Compensation Board. You can search for an authorized provider on the Board website, wcb.ny.gov. 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 an 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 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, but it isn't required. The Workers' Compensation Board sets their fees, which 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 employer about disability benefits and ask for a DB-450 claim form. If your 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. An injury can also cause family or financial problems. The Workers' Compensation Board has vocational counselors and social workers to help. More information is also available on the NYS Workers' Compensation Board website at: 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 and may request additional information if necessary.

Important Contact Information

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

Warren County Self-Insurance Department
1340 State Route 9, Lake George NY 12845
518-761-6528, Fax 761-6249, e-mail warrencountyinsurance@warrencountyny.gov

CC#_________

Workers' Compensation Medical Visit Encounter Form

***To the Injured Worker:** 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:____/____/____

Print Providers Name:____

Facility Name:____

Please Fax this form immediately to: 518-761-6249
or email to warrencountyinsurance@warrencountyny.gov

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 or call our customer service team for a list of network pharmacies in your area **888-700-0992**.

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

SUPERVISORS REPORT OF INCIDENT INVESTIGATION

This form is to be used to determine the root cause of an incident and how a similar incident can be prevented in the future. Supervisors should complete this form for every incident involving employee injury or near miss. Please print.

Employee Injured:______________________________Date of incident:__________ Time:__________

What was the task or job just before the incident occurred, include who was on site or involved? (i.e. Employees John & Tom were replacing a culvert at 123 Route 5 Whooville)

What was the incident? (While Tom was lifting the culvert with the loader the chain broke and culvert fell on John)

When did you know about the incident?

What body parts did the employee injure and to what extent? (Be specific, i.e. bruised right leg below knee)

Was there any damage to property or equipment? (Note: auto & property damage may require additional forms.)

What was the ROOT cause(s) of the incident? (ask "why" until root cause(s) is determined)

Was the incident preventable?
What actions will / should be taken to eliminate future repeats of the incident? (i.e. training, use PPE, other equipment)

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.

Signature:____Date:____________________

Workers' Compensation Board

State of New York - Workers' Compensation Board

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

C-2F

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

Employee Name ______

WCB Case Number (JCN) ______ **Date of Injury** ______

Claim Administrator Claim Number ______

INSURER / CLAIM ADMINISTRATOR INFORMATION

Insurer Name Warren County Self-Insurance **Insurer ID** W874754

Name Warren County Self-Insurance

Info/Attn ______

Address 1340 State Route 9

City Lake George **State** NY

Postal Code 12845 **Country** USA

Claim Admin ID ______

EMPLOYEE INFORMATION

First Name ______ **Middle Name/Initial** ______

Last Name ______ **Suffix** ______

Mailing Address ______

City ______ **State** NY

Postal Code ______ **Country** USA

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 Warren County DSS **Employer FEIN** 14 600 2576

UI Number 04 60 0513 **Manual Classification Code** ______

Industry Code ______

Info/Attn Christian Hanchett

Mailing Address 1340 State Route 9

City Lake George **State** NY

Postal Code 12845 **Country** USA

Physical Addr 1340 State Route 9, Human Services Building

City Lake George **State** NY

Postal Code 12845 **Country** USA

Contact Name Christian Hanchett

Contact Business Phone Number 518-761-6310

INSURED INFORMATION

Insured Name Warren County DSS **Insured FEIN** 14 600 2576

Insured Type ☐ Insured ☒ Self-Insured ☐ Uninsured **Insured Location ID** ______

Policy Number ID n/a

Policy Effective Date 7/1/1983 **Policy Expiration Date** continues

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** ______

Wage Reporting:

The employer must report the Wages of an employee who has missed time from work due to a work related injury.

To do this complete form C-240, "Employer's Statement of Wage Earnings" as soon as it is known that the employee will be out of work for more than 7 calendar days.

The Workers' Compensation rate is 2/3 of the average weekly wage for the year prior to the injury; subject to statutory maximums and minimums. If the employee has not worked a year, use the wages of a comparable employee. The injured workers compensation rate is based on the year prior to the injury therefore it does not change. NYS Workers' Compensation Law provides an unpaid 7 calendar day waiting period unless the disability exceeds 14 calendar days. If the disability exceeds 14 calendar days the waiting period is waived and payment begins from date of disability. The waiting period is cumulative days.

Volunteer Fire Workers and Ambulance Workers do not receive payments based on wage. VF & VAW receive payments based on disability as per the following schedule:

Disability	Weekly Rate
75% to 100%	$400 (as of 7/1/22 $650)
50% to 74%	$268
25% to 49%	$30
0 to 24%	$0

Payments in Volunteer Firefighter and Volunteer Ambulance Worker cases begin from the date of disability, there is no waiting period. Thus Volunteer Firefighters and Volunteer Ambulance Workers do not have to report wages on the C-240 form. The rest of this section does not apply to VF & VAW.

Employers must complete questions 1-8 on Form C-240 for the injured worker, as well as the Injured Worker Payroll table on page 2 of the form. Employers must also complete the new Employee of the Same Class section on page 2 of the form (worker of the same class payroll) in any case where the employer is uncertain whether the injured worker worked a substantial part of the year. When completing this section, employers should also write the name of the worker and that worker's title where indicated on the form. If the employer is submitting payroll documents in lieu of completing the payroll table(s), then page 2 of the form should not be included in the submission.

Items on the bottom of page 1 of the C-240 are important please complete the "prepared by" section in full.

Please complete the form fully. If employee is paid bi-weekly it is not necessary to list the weeks separately. **Indicate the total days paid and total gross pay at the bottom right side of the Payroll box**. You must complete the total days and total paid, this is very important, the form will be returned to you if not complete.

If the injured employee is currently using sick/vacation/personal time, please put a note in with the C-240 to alert the Self-Insurance Plan. If we do not know about the use of time, we will pay the employee the Compensation due and you (the employer) will not get reimbursed. You will need to file a reimbursement request when the employee's time is exhausted. Please see next section.

This form is available at:

www.wcb.state.ny.us/content/main/forms/C240.pdf or www.warrencountyny.gov/insurance. You can complete, print or save, and then mail or email to Self-Insurance.

Workers' Compensation Board

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

Claim Information - ALL COMMUNICATION SHOULD INCLUDE THESE NUMBERS

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

Injured Worker Information

Last Name: ________ First Name: ________ MI: __

Mailing Address: ________ Line 2: ________

City: ________ State: ______ Zip Code: ________

Job Title: ________ Social Security #: ________

Insurer Information

Insurer Name: Warren County Self-Insurance Plan Insurer ID (W#): W874754

Mailing Address: 1340 State Route 9 Line 2: ________

City: Lake George State: NY Zip Code: 12845

Insurer Phone #: 518-824-6610 Insurer Fax #: 518-761-6249 Email Address: burnhamj@warrencountyny.gov

Employer Information

Employer Name: ________

Mailing Address: ________ Line 2: ________

City: ________ State: ______ Zip Code: ________

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

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

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

1. Payroll information is: ☐ attached ☐ completed on page 2

2. Did the injured worker's compensation include board, rent, housing, tips and/or gratuities, in addition to gross weekly earnings? ☐ Yes ☐ No

   If Yes, what was the weekly value: ________

   Nature of the compensation:

3. Basis for the injured worker pay rate is: ☐ hourly ☐ daily ☐ weekly ☐ monthly ☐ annually

4. The injured worker works a: ☐ 5 ☐ 6 ☐ 7 ☐ Other day week. If Other, Explain: ________

5. Total days paid in the preceding 52 weeks: ____ 6. Total gross amount paid including overtime in the preceding 52 weeks: ________

7. Was there any wage adjustment made that affected the 52-week period? (If injured worker was in military service, please indicate and provide date of discharge.) ☐ Yes ☐ No

   If "Yes", explain:

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

   If Yes, provide dates of layoff : ________

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

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

Last Name: ________ First Name: ________ MI: __

Employer Name: ________

Official Title: ________ Daytime Phone #: ________

Email Address: ________ Date of this Report: ________

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

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

Week No.	Week Ending Date	Days Paid	Gross amount paid including overtime	Week No.	Week Ending Date	Days Paid	Gross amount paid including overtime	Week No.	Week Ending Date	Days Paid	Gross amount paid including overtime
1				19				37			
2				20				38			
3				21				39			
4				22				40			
5				23				41			
6				24				42			
7				25				43			
8				26				44			
9				27				45			
10				28				46			
11				29				47			
12				30				48			
13				31				49			
14				32				50			
15				33				51			
16				34				52			
17				35				Total:			
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: wcbclaimsfiling@wcb.ny.gov
WCB Web Upload Link: https://wcbdoc.services.conduent.com/

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

Requesting Reimbursement For Wages Paid:

(This section not applicable to Volunteer Firefighters and Volunteer Ambulance Workers')

If you have paid the employee directly while he/she was out of work due to a Workers' Compensation injury, you can request reimbursement from the Plan. However, the request must be made on the attached form and must be made prior to any award by the Workers' Compensation Board.

The NYS Workers' Compensation Law Section 25 (4) (a) reads:
"Advance payments of compensation; employer reimbursements; receipts for payment. (a) If the employer has made advance payments of compensation, or has made payments to an employee in like manner as wages during any period of disability, he shall be entitled to be reimbursed out of an unpaid installment or installments of compensation due, provided his claim for reimbursement is filed before award of compensation is made, or if insured, by the insurance carrier at the direction of the board, unless he shall file a waiver of reimbursement with the chairman, in which event compensation shall be paid to the claimant notwithstanding the advanced payments."

The reimbursement is made at the compensation rate calculated from the "Statement of Wages" (C-240). Thus the total requested amount is not reimbursed in most cases. (However, in some cases you will receive the total amount after direction from the Workers' Compensation Board. This usually occurs in cases where the claimant receives a schedule loss of use award for the injury and often takes years to come to a resolution.)

This form is also available on our website at www.warrencountyny.gov/insurance

Instructions for Completing the "Reimbursement Request."

Claimant -the employee.

Received from -the town, city or village, etc..

$ -indicate the gross amount paid to the employee in sick time wages for the work related injury.

...disease sustained by me on -indicate the date of the work related injury/illness.

...wages cover period from -the period the sick time paid was for including the last day indicated.

Employee signature -the claimant. (not necessary if the employee is not readily available)

Sign and complete the bottom of the request.

Send the original and one copy to the Plan.

WARREN COUNTY SELF-INSURANCE PLAN
1340 STATE ROUTE 9
LAKE GEORGE NY 12845

EMPLOYER'S REQUEST FOR REIMBURSEMENT

WORKERS' COMPENSTATION BOARD CASE NO. _________________	WARREN COUNTY SELF-INSURANCE Carrier ID# W874754 Carrier Case No. _______________
CLAIMANT:___________________________________	

RECEIPT FOR WAGES ADVANCED

Received from____employer,

____________________________________dollars and __________________________cents ($________)

as wages during my absence from work on account of disability, which I allege resulted from accidental

injury or occupational disease sustained by me on _____________________. These wages cover period

from___________________________ to ___________________________ (Incl.)

________________________________ ____________________________________
(date) (Employee's Signature)

CLAIM FOR REIMBURSEMENT

To the Workers' Compensation Board:

In accordance with Section 25 of the Workers' Compensation Law, the undersigned employer, for wages paid during the above noted period of absence, hereby requests reimbursement at the compensation rate or in the event of a schedule loss, full amount of wages paid.

Date:__________________ ______________________________________
(Employer)

____
(Signature and Title)

FORM C-107

When An Employee Returns To Work After Losing Time Due To Injury:

(This form is not applicable to Volunteer Fire Companies or Ambulance Squads.)

You will need to notify the Plan immediately that the employee has returned to work. This can be done with a phone call, email, fax etc.

Additionally you will need to complete the C-11 form, "Employer's Report of Injured Employee's Change in Employment Status Resulting from Injury". The C-11 form notifies the plan and the Workers' Compensation Board of any change in employment status as a result of a work related injury. The C-11 form is usually used to indicate return to work. The directions follow for that usage. However, the C-11 form must also be used if you have changed the employees work days/ work hours/ earnings due to the injury.

This form is also available on our website at www.warrencountyny.gov/insurance

Instructions for C-11:

Fill in all boxes as applicable. Self-Insurance can fill in the case numbers if you don't know them.

Below the "Insurer Information" area there are two fields that are always filled in:
Date of first full day employee lost from work
Date employee first returned to work

STOP HERE if this is the first return to work since the original date of injury. Complete the bottom of the form. Email, fax, mail form to Warren County Self-Insurance.

If this is not the first time the employee has returned to work following the date of original injury:

There should have been at least one previous C-11 filed. Complete:
"Loss of time resulting from above injury since initial date of lost time or last C11 filed with the Board."
Note that these fields will only include information that applies to the current time away from work. You will have already filed a C11 with any other time periods indicated.

WHEN AN EMPLOYEE HAS RETURNED TO WORK AND GOES OUT OF WORK AGAIN:

It is not necessary to complete any form. However, you should contact the Plan and inform them of the information that you have, doctors notes, etc. Also advise the Plan if the employee is remaining on the payroll while using accrued leave time and the date that such time expires.

When the employee returns to work after the absence, follow the notes above to file necessary C-11.

New York State Workers' Compensation Board

EMPLOYER'S REPORT OF INJURED EMPLOYEE'S CHANGE IN EMPLOYMENT STATUS RESULTING FROM INJURY

C-11

PO Box 5205, Binghamton, NY 13902-5205

- Web Upload Link: https://wcbdoc.xrxfs.com/login.aspx
- Email Filing: wcbclaimsfiling@wcb.ny.gov

This report is to be filed directly with the Chair, Workers' Compensation Board as soon as the employment status of an injured employee, as reported on First Report of Injury, or on a previous Form C-11 or EC-11, is changed. Change in employment status includes return to work, discontinuance of work, increase or decrease of regular hours of work and increase or reduction of wages. **A copy should also be sent to your insurer.**

Claim Information - ALL COMMUNICATION SHOULD INCLUDE THESE NUMBERS

Date of Injury/Illness: ______ WCB Case #: ______

Claim Administrator Claim (Carrier Case) #: ______

Employee Information

Last Name: ______ First Name: ______ MI: ___

Mailing Address: ______ Line 2: ______

City: ______ State: ______ Zip Code: ______ Country: ______

Daytime phone #: ______ Email Address: ______

Social Security #: ______ Date of Birth: ______ Gender: ◯ M ◯ F ◯ X

Employer Information

Employer Name: ______

Mailing Address: ______ Line 2: ______

City: ______ State: ______ Zip Code: ______ Country: ______

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

Insurer Information

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

Mailing Address: ______ Line 2: ______

City: ______ State: ______ Zip Code: ______ Country: ______

Insurer Phone #: ______

Date of first full day employee lost from work: ______ Date employee first returned to work: ______

Loss of time resulting from the above injury since initial date of lost time or last C-11 filed with the Board:

Loss of Time Start Date	Return To Work Date	Reason

As a result of the above injury, was there an increase or decrease in hours worked or wages paid? ◯ Yes ◯ No

If yes, enter status of change below:

Employment Status	Effective Date	Hours per Day	Days per Week	Earnings	Remarks
Prior to Injury					
Changed To					

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:

Last Name: ______ First Name: ______ MI: ___

Employer Name: ______

Official Title: ______ Phone #: ______

Email Address: ______ Date of this report: ______

Employee Expense Reimbursement

Occasionally your employee will pay for items reimbursable under the Workers' Compensation Law. Examples of such items are: crutches or other apparatus properly prescribed by the doctor and for carfares, mileage or other necessary expenses going to and from his/her doctor's office or the hospital. Additionally, eyeglasses (if broken in an occupational injury) are reimbursable. The employee must complete Workers' Compensation Board form C-257, "Claimant's Record of Medical and Travel Expenses".

The employee shall complete the columns for the description, date, amount, and submit it to the Warren County Self-Insurance Plan along with the original receipts for the items. The Plan will then audit the request and pay all appropriate charges as soon as practical.

Mileage is payable to and from treating medical provider and independent medical examiner.

See next page for current mileage rates.

Travel Reimbursement Rates

Effective Date	Rate (Cents Per Mile)
1-1-82	23
2-27-89	24
2-20-90	26
1-1-91	27.5
1-1-92	28
1-1-94	29
1-3-95	30
1-2-96	31
1-1-97	31.5
1-1-98	32.5
4-1-99	31
1-1-00	32.5
1-1-01	34.5
1-1-02	36.5
1-1-03	36
1-1-04	37.5
1-1-05	40.5
9-1-05	48.5
1-1-06	44.5
1-1-07	48.5
1-1-08	50.5
7-1-08	58.5
1-1-09	55
1-1-10	50
1-1-11	51
7-1-11	55.5
1-1-13	56.5
1-1-14	56
1-1-15	57.5
1-1-16	54
1-1-17	53.5
1-1-18	54.5
1-1-19	58
1-1-20	57.5
1-1-21	56
1-1-22	58.5
7-1-22	62.5
1-1-23	65.5

State of New York

WORKERS' COMPENSATION BOARD

CLAIMANT'S RECORD OF MEDICAL AND TRAVEL EXPENSES AND REQUEST FOR REIMBURSEMENT

CLAIMANT'S NAME	WCB CASE NO.	SOCIAL SECURITY NO.

RESIDENTIAL ADDRESS	MAILING ADDRESS (IF DIFFERENT)

In connection with the above workers compensation case, you are entitled to be reimbursed for (1) medications or supplies properly prescribed by your health care provider that you paid for yourself and for (2) fares, automobile mileage or other necessary expenses going to and from your health care provider's office or the hospital.

To help you keep a record of such expenses we have provided this form. In order to help insure that you are properly reimbursed, list each item of expense below -- whether or not you obtained a receipt (wherever possible obtain receipts). **Submit the completed form and copies of all receipts or bills to the workers' compensation insurance carrier (or to your employer, if self-insured) and to the Workers' Compensation Board.** (See Board address on reverse.) It is suggested that you retain a copy of the receipts and bills for your records.

NATURE OF EXPENSE	DATE	AMOUNT

Continue on Reverse.

C-257 (11-21)

NATURE OF EXPENSE	DATE	AMOUNT

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

Address for email filing: wcbclaimsfiling@wcb.ny.gov
www.wcb.ny.gov

The Claims Process after the report is received at Self-Insurance:

Self-Insurance reviews the accident report forms on the date that they are received and usually opens the case file within 1 business day. Upon receipt of the claim we will be working towards resolving the claim to the employer's best interest while providing the necessary benefits as required by law to the employee.

When the case file is opened, a four digit carrier case number is assigned. This number identifies the claim at Warren County. The claim is carefully reviewed and appropriate action is taken. The first action taken for claims involving medical treatment includes sending the claimant (your employee) an information packet. The packet includes: a case information sheet with the carrier information; a "statement of rights" (C-430); instructions about the Workers' Compensation process with Warren County; a claimant questionnaire; notice to employees receiving compensation; pharmacy network information; diagnostic network information; and blank workers' compensation encounter forms. A sample copy of the informational packet follows.

It is important that your employee complete and return all forms. This aids in the claims process and enables us to be the most efficient at handling claims.

Cases are handled many ways, depending on the circumstances in each case.

Sometimes we feel a case would benefit from the addition of a Case Manager. If so, we request the service from an independent case management company. The Case Manager is a nurse that is specially trained in rehabilitation services. The Case Manager will often contact you as the employer, identify himself or herself and explain case management services. We request that you cooperate fully with the Case Manager, as it has proven to be very useful. The Case Manager also contacts the claimant. The Case Manager coordinates specialty requests (i.e. physical therapy, durable medical equipment) and assists the Plan and the Employer in any way possible. Oftentimes this means facilitating a quicker return to work. Additionally, our Case Manager will notify us if the claimant requires encouragement in returning to work or may need surveillance.

If the employee has missed work or sought medical care beyond first aid, we will forward the accident report to the Workers' Compensation Board and formally accept or deny the claim. The Workers' Compensation Board, Albany office, is the NY state agency that oversees Workers' Compensation.

If the employee is out of work and is a COUNTY employee, the Plan will send the appropriate letter under Civil Service Law sec 71. If the employee is NOT a COUNTY employee then the municipality is reminded to review this law and send the letters when appropriate.

We sometimes use surveillance on questionable cases. However, we must have some evidence to substantiate the costs of investigation. You, as the employer, often know much more about your employee than we do. If at any time you feel the claimant is in need of investigation, we request you contact us immediately with your information.

We continually monitor each claim, we will at times request additional information from you, and are always open to any information or questions you have for us.

Most cases at some point will be indexed and assigned a number by the Workers' Compensation Board. As the employer on record, you will be notified when this occurs. You will continue to receive notices about the case until resolution of the claim. Warren County as the carrier should also receive these notices from the NYS Workers' Compensation Board.

Once the claimant returns to work we continue to follow the claim until such time as there is no activity for at least 6 months; the claim is closed by the Workers' Compensation Board; or the Workers' Compensation Board takes some other action.

Actions taken by the Workers' Compensation Board include hearings to determine if the claimant suffers from permanent restricted use of a body part due to the injury. If that does occur, the Plan would have had the claimant present for an Independent Medical Exam to determine the percentage loss of use. The claimant's own health provider would have also commented on percentage loss of use. We call these Schedule Loss cases and it usually takes at least one year after last medical treatment to have an estimate of loss of use. If the Workers' Compensation Law judge determines that there is indeed a loss of use, the judge will determine to what extent based on the medical evidence and may make an award based on the percentage. The Workers' Compensation Board has a table that gives the amount of weeks awarded for each body part and percentage loss of use, thus a "schedule". The claimant would then be paid a monetary award based on the weeks in the schedule. The case is then usually closed.

Sometimes the actions taken by the Workers' Compensation Board determine that there is a permanent disability to the claimant. Permanent Disabilities are determined by a percentage based on medical evidence. Each case and the particulars of such determine if payments will continue to the claimant or not.

Some permanent disability cases can be resolved with an agreement between all parties under Section 32 of the Workers' Compensation Law. These cases would then most likely be closed with no medical or indemnity paid in the future. Again, the case particulars dictate if we would seek such resolution to a claim.

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**

Dear Workers' Compensation Claimant:

This office has received a workers' compensation claim submitted on your behalf by your employer. The information referenced on the attached forms relate to that report.

Enclosed are a Statement of Rights and a Compensation Report. These are for your records. Please keep them in a safe place. The Statement of Rights explains your rights under the Workers' Compensation Law, Volunteer Firefighters Benefits Law or Volunteer Ambulance Workers' Law. The Compensation Report has important case information; please **show your Compensation Report to each medical provider that you visit regarding this injury.**

When visiting the doctor each time, along with showing your insurance information listed on the Compensation Report, please provide one copy of the "Workers' Compensation Medical Visit Encounter Form" to your medical provider, ask your provider to complete it and fax or mail it to our office immediately following your visit. We have enclosed a few copies of the "Workers' Compensation Medical Visit Encounter Form" for your use (they may be duplicated). Your benefits are dependent upon our receiving medical reports promptly.

A claim form (C-3, VF3 or VAW3) from the Workers' Compensation Board is enclosed. Instructions for completion are on the form.

Please complete the forms below and return them to our office in the enclosed self-addresses stamped envelope within 10 days:

Notice to Employees Receiving Workers' Compensation Benefits (WC Form 7)
Claimant Questionnaire (WC Form 9)
Claimants Authorization to Disclose Workers' Compensation Records (OC-110A)

If you were truly injured on the job, be assured, your medical bills will be paid and you will receive compensation for any time lost under the Workers' Compensation Law, Volunteer Firefighters Benefits Law, or Volunteer Ambulance Workers' Law. However, if fraud is suspected, be advised, this carrier will actively investigate any claim suspected of fraud.

Remember, each time you go to the doctor, to have a "Workers' Compensation Medical Visit Encounter Form" completed and returned to Self-Insurance. Your employer, Chief or Squad Captain, may also request a note specifying whether you can return to your duties (with restrictions or at full duty), or that you are disabled and cannot return to duty.

Warren County currently contracts with One Call Medical for **diagnostic radiology testing**. If your medical provider recommends diagnostic testing, please show them the form DT-1 enclosed.

Warren County contracts with AWPRx for **pharmacy benefits** services. Your employer should have provided pharmacy benefits information at the time of your injury. If your injury requires pharmaceuticals, you will receive a pharmacy benefits card and more information about the program in the mail. **You must use these to obtain pharmaceuticals.**

Out-of state treatment will be paid as per the NYS WCB Schedule of Medical Fees. You may be responsible for any additional balance.

Warren County employs the case management skills of certified case managers. Case managers aid in the efficient handling of your claim and in the authorization of various medical tests and treatments that you may require. The services of the case manager will be at no cost to you. Depending on the circumstances of your case, you may or may not be assigned a nurse case manger.

The Warren County Self-Insurance Department will be administering your Workers' Compensation claim. If you have any questions regarding your claim, please call 518-761-6528. Thank you for your attention and cooperation.

Occupational injury/illness
STATEMENT OF RIGHTS

Workers' Compensation Board

To all workers who are injured while working or who suffer from an occupational disease: You may be entitled to workers' compensation benefits

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

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

To file a claim:

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

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

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

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

WCB.NY.GOV

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

COMPENSATION REPORT

Case No.: XXXX (Refer to this number when contacting Warren Co.)

Name: XXXX
Address: XXXX
XXXX
Phone No.: XXXX

Employer: XXXX
Injury: XXXX

Date of: XXXX
WCB #: XXXX
SSN#: XXXX

THIS NOTICE WILL CONFIRM THAT A WORKERS' COMPENSATION CASE HAS BEEN ESTABLISHED IN YOUR NAME. PLEASE DO NOT DISCARD THIS NOTICE, IT CONTAINS IMPORTANT INFORMATION ABOUT YOUR CASE
THE WORKERS' COMPENSATION INSURANCE CARRIER FOR THIS CASE IS:

WARREN COUNTY SELF-INSURANCE
1340 STATE RT. 9
LAKE GEORGE, NY 12845
CARRIER CODE: W874754
Tel: (518) 761-6528
Fax: (518) 761-6249
email: warrencountyinsurance@warrencountyny.gov

**** TAKE THIS FORM WITH YOU WHEN SEEKING TREATMENT FOR THIS INJURY, IT IS VERY IMPORTANT TO NOTIFY ALL MEDICAL PROVIDERS OF THE ABOVE INSURANCE INFORMATION.**

DATED: 11/25/20XX **ADJUSTER:**

WCB FORM C-430 - STATEMENT OF RIGHTS, ATTACHED

Warren County Self-Insurance Department
1340 State Route 9, Lake George NY 12845
518-761-6528, Fax 761-6249, e-mail warrencountyinsurance@warrencountyny.gov

CC#_________

Workers' Compensation Medical Visit Encounter Form

***To the Injured Worker:** 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:____/____/____

Print Providers Name:____

Facility Name:____

Please Fax this form immediately to: 518-761-6249
or email to warrencountyinsurance@warrencountyny.gov

Warren County Self-Insurance Department
1340 State Route 9, Lake George NY 12845
518-761-6528, Fax 761-6249, e-mail warrencountyinsurance@warrencountyny.gov

CC#_________

Workers' Compensation Medical Visit Encounter Form

***To the Injured Worker:** 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:____/____/____

Print Providers Name:____

Facility Name:____

Please Fax this form immediately to: 518-761-6249
or email to warrencountyinsurance@warrencountyny.gov

Warren County Self-Insurance Department
1340 State Route 9, Lake George NY 12845
518-761-6528, Fax 761-6249, e-mail warrencountyinsurance@warrencountyny.gov

CC#_________

Workers' Compensation Medical Visit Encounter Form

***To the Injured Worker:** 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:____/____/____

Print Providers Name:____

Facility Name:____

Please Fax this form immediately to: 518-761-6249
or email to warrencountyinsurance@warrencountyny.gov

Workers' Compensation Board

Employee Claim

C-3

State of New York - Workers' Compensation Board

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

WCB Case Number (if you know it): ____________________

A. YOUR INFORMATION (Employee)

1. Name: ____________________ First ____ MI ____ Last ____ 2. Date of Birth: ____/____/____
3. Mailing address: ____________________ Number and Street/PO Box/Apartment No. ____ City ____ State ____ Zip Code ____
4. Social Security Number: ____-____-____ 5. Phone Number: (____)________ 6. Gender: ☐ M ☐ F ☐ X
7. Will you need a translator if you have to attend a Board hearing? ☐ Yes ☐ No If yes, for what language? ____________

B. YOUR EMPLOYER(S)

1. Employer when injured: ____________________ 2. Phone Number: (____)________
3. Your work address: ____________________ Number and Street ____ City ____ State ____ Zip Code ____
4. Date you were hired: ____/____/____ 5. Your supervisor's name: ____________
6. List names/addresses of any other employer(s) at the time of your injury/illness: ____________________
7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

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

1. What was your job title or description? ____________________
2. What types of activities did you normally perform at work? ____________________
3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: ____________
4. What was your gross pay (before taxes) per pay period? ____________ 5. How often were you paid? ____________
6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: ____________

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: ____/____/____ 2. Time of injury: ________ ☐ AM ☐ PM
3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) ____________________
4. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? ____________________
5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) ____________________
6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) ____________________
7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): ____________________

YOUR NAME: ______________________________ **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. Have you had another injury to the same body part, or a similar illness? ☐ Yes ☐ No
   If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**
   ____
   ____
   ____
6. Was the previous injury/illness work related? ☐ Yes ☐ No
   If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

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

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

Employee's Signature: ____________ Print Name: ____________ Date: ____/____/____

On behalf of Employee: ____________ Print Name: ____________ Date: ____/____/____

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

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

Signature of Attorney/Representative (if any): ____________ Date: ____/____/____

Print Name: ____________ Title: ____________

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

C-3.0 (6-22) **Page 2 of 2**

Section F - Medical Treatment for This Injury or Illness:

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

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

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

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

Your Rights:

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

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

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

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.).

Warren County Self-Insurance Department
1340 State Route 9, Lake George NY 12845
518-761-6528, Fax 761-6249, e-mail warrencountyinsurance@warrencountyny.gov

CC#____________

NOTICE TO EMPLOYEES RECEIVING WORKERS' COMPENSATION BENEFITS

If you are receiving weekly workers' compensation, you must report any additional earnings you receive to the Warren County Self-Insurance Department. "Earnings" includes any cash, wages, or salary received from

1. self-employment
2. any employer other than the employer where you were injured.

"Earnings" also include commissions, bonuses, and the cash value for all payments received in any medium other than cash (e.g. a building custodian receiving an apartment rent free).

3. you must also report any activity you perform as an unpaid volunteer.

Failure to report earnings as defined will subject you to criminal prosecution and civil liability, including the suspension or forfeiture of your benefits.

Your endorsement on a benefit check, or deposit of the check into an account, is your statement that you are entitled to receive workers' compensation benefits. Your signature on a benefit check is a further affirmation that you have made no false claims or statements or concealed any material fact regarding your workers' compensation claim.

I have read and understand the above.

Dated:____________________ ________________________
Employee signature

WC Form 7

CC#__________ **Warren County Self-Insurance Department**

1340 State Route 9, Lake George NY 12845, 518-761-6528, Fax 761-6249, e-mail warrencountyinsurance@warrencountyny.gov

CLAIMANT QUESTIONNAIRE

Name:______________________________ Date of Injury:______________________________

Current Address:____
Telephone #:______________________________E-mail address:______________________________
Date of Birth:______________________________Social Security #______________________________

Legal Name as indicated on your Social Security card:______________________________
Other names by which you have been known:______________________________

Since you were injured have you worked or performed any activity for which you expect to get paid?
(circle one) YES NO
If yes, date:______________________ If no, last day worked:______________________
If No, were you out of work due solely to the injury on the date above? Yes No (explain)

Since you were injured have you performed any activity as a volunteer? Yes No explain below:

____

Have you participated in any activity for recreation (bowling, golf, crafts etc)? Yes No explain below:

____

Did the above named injury happen at your regular job? Yes No

At the time of your injury, were you employed by anyone other than the employer at which your injury occurred? Yes No
If Yes, please give name and address of other employer:______________________________
What are your gross weekly earnings at the other employer:______________________________

Have you ever received disability benefits (non-work related injury) for a condition similar to this, or this part of your body? Yes No if yes explain______________________________

Have you ever had an injury to a similar part of your body (at work or not)?______________________________
If so, please explain (include type of injury, dates, carrier, etc)______________________________

____

Have you ever received workers' compensation benefits in the past?________ If so, explain the injury below:

____

If so, please provide the names of treating physicians/ chiropractors and the approximate dates:

____

Please provide the name and address of your family physician, specialists & chiropractors:______________

____

Please provide the names of individuals with which we may discuss your case (ie: family)______________

It is a crime punishable as a Class A Misdemeanor under the laws of the State of New York for a person in and by a written instrument to knowingly make a false statement or to make a statement which such person does not believe to be true.

______________________ ______________________________

Today's Date Employee (claimant) Signature

WC Form 9

Workers' Compensation Board

CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS

(Pursuant to Workers' Compensation Law Section 110-a)

PO Box 5205, Binghamton, NY 13902-5205 • www.wcb.ny.gov

CLAIMANTS ARE PROHIBITED FROM AUTHORIZING RELEASE OF WORKERS' COMPENSATION INFORMATION TO PROSPECTIVE EMPLOYERS OR IN CONNECTION WITH ASSESSING FITNESS OR CAPABILITY OF EMPLOYMENT.

PLEASE COMPLETE ALL ITEMS. AN INCOMPLETE FORM WILL DELAY THE PROCESSING OF YOUR REQUEST.

Claimant's Name	Claimant's Social Security or Tax Identification Number	Case Number ☐ WCB ☐ DB ☐ Discrimination ☐ PFL and/or Date of Accident

IF RELEASE IS AUTHORIZED FOR ADDITIONAL CASE FILE(S), IDENTIFY BELOW BY WCB/DB/DC/PFL CASE NUMBER AND/OR DATE OF ACCIDENT(S)

All prior injuries/cases that I have filed with the NYS Workers' Compensation Board.

INSTRUCTIONS:

Submit original to the Workers' Compensation Board and retain a copy for your records. *Authorization for disclosure of records for certain purposes is not valid under the law. See excerpt of WCL Section 110-a on the reverse of this form.* This authorization is effective until it is revoked by the claimant. Claimant may revoke this authorization at any time upon written notice to the Workers' Compensation Board.

THIS AUTHORIZATION DOES NOT PERMIT YOU TO OPEN AN INDIVIDUAL eCASE ACCOUNT OR TO VIEW CASES VIA eCASE OUTSIDE OF A BOARD LOCATION.

Pursuant to Section 110-a of the Workers' Compensation Law, I, ______________________________,
(CLAIMANT'S NAME)

represent that I am a person who is/was the subject of the workers' compensation cases(s) indicated above, and I authorize the Workers' Compensation Board to discuss the above-referenced Workers' Compensation Board records with and/or release a copy of the above-referenced records to Warren County Self-Insurance Plan and it's representatives,
(NAME OF A SPECIFIC PERSON, CORPORATION, ASSOCIATION OR PUBLIC OR PRIVATE ENTITY)

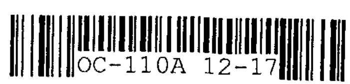
at 1340 State Route 9, Lake George NY 12845.
(ADDRESS)

I understand that the requesting party may be required to pay a statutory fee prior to being provided copies of these records by the Workers' Compensation Board.

______________________________ ______________
Claimant's Signature (ink only - use blue ink if possible) Date

Failure to provide the information requested on this form will not result in the denial of your authorization, but may delay the processing of your request. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your request.

OC-110A (12-17)
Prescribed by the Chair, Workers' Compensation Board



THIS NOTICE APPLIES ONLY IF YOUR MEDICAL PROVIDER RECOMMENDS A DIAGNOSTIC TEST

Notice That Claimant Must Arrange for Diagnostic Tests & Examinations through a Network Provider

DT-1

State of New York - Workers' Compensation Board

Claimants are required to obtain Diagnostic Tests and Examinations through the Carrier's Diagnostice Testing Network(sw) identified below. This Notice is supplied to the Claimant and Treating Medical Provider pursuant to Workers' Compensation Law §13-a(7) and 12 NYCRR 325-7. Failure to provide the required notice relieves the Claimant of his/her obligation to use the diagnostic testing network(s).

Warren County SIF

Date of Notice: ________

Check the applicable box below:

[X] Notice to the Claimant

Claimant: ________ (First Name) ________ (Middle Initial) ________ (Last Name) WCB Case Number: ________

Mailing Address: ________

Carrier Case Number: ________

[ ] Notice to the Treating Medical Provider

Name of Treating Medical Provider: ________ Authorization No.: ________

Mailing Address: ________

Identify the Diagnostic Examination or Test that the Claimant must schedule using the Diagnostic Testing Network (check all applicable boxes):

[ ] All [X] MRI [X] CT [ ] EMG/NCS [X] Diagnostic Ultrasound [ ] X-Ray

[ ] Other: ________

schedule a diagnostic examination or test, contact the Diagnostic Testing Network listed below:

Diagnostic Testing Network

Identify the Diagnostic testing network name, address, toll-free telephone number and any web address or e-mail contact information below:

Diagnostic Testing Network: OCM IPA, Inc. (One Call Medical)

Mailing Address: 20 Waterview Boulevard, Parsippany, NJ 07054

Phone Number: (800) 872-2875 Fax Number: (866) 632-2161

Web Address: www.onecallmedical.com E-mail Address: referrals@onecallmedical.com

STATEMENT OF RIGHTS AND OBLIGATIONS - DIAGNOSTIC TESTING NETWORKS (WCL §13-a(7) AND 12 NYCRR §325-7)

1. The claimant will receive the name, address and phone number of at least five [5] providers. The providers must be located within a reasonable distance from the claimant's home or work. The network must provide the claimant with all providers if there are fewer than five [5] within a reasonable distance.
2. The test must be scheduled and performed within five [5] business days of the request. If the network asks the carrier to approve the test, it must still be performed within five [5] business days of the request from the claimant's doctor.
3. The claimant may select any network provider to perform the test.
4. The claimant may discuss with his or her doctor which provider to choose.
5. The claimant should share this notice with all of his or her doctors.
6. The claimant does not have to use a network provider under these circumstances:
   a. The provider can't schedule the test within five [5] business days.
   b. The carrier has challenged (controverted) or will controvert the claim.
   c. In a medical emergency.
   d. For x-rays taken during an office visit and used for diagnosis and treatment of: fractures, possible fractures, joint dislocations, tumors, infections, loosening of surgical implants, dislocation of prosthetic joints, spinal instability, or follow-up to surgery.
7. If the carrier doesn't provide the required notice, the carrier must pay for tests outside of the network.
8. On written request, the network will provide the actual test film, data or digital images to the claimant's doctor. These items will be sent to the claimant's doctor with the report or within three [3] business days of receipt of the written request. A doctor may order a second test from the network for the purpose of obtaining an accurate diagnosis as set forth in the Medical Treatment Guidelines if the quality of the test is inadequate.
9. The claimant is entitled to reimbursement for reasonable travel costs to and from the provider.

More information on diagnostic testing networks is available in Subject Number 046-480, located on the Board's website under Board Bulletins and Subject Numbers.

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

Independent Medical Exams:

Oftentimes the Plan will require your employee to be seen by an Independent Medical Examiner. These exams are necessary in many cases and are performed by either a medical doctor or chiropractic doctor that specializes in independent exams.

You, as the employer, may have your own policy about release time for such exams. Many employers require the employee to use available leave time for the time away from work due to the exam. Some employers do not.

Excess Insurance:

The Warren County Self-Insurance Plan currently purchases Excess Workers' Compensation part 1 coverage for each participant. This covers claims per occurrence, either one claim or several during the same occurrence. The current Self-Insured retention on this policy is $2,000,000 for each accident. Thus the Plan would be responsible for the first $2,000,000 in claim cost for either one particular claim or several claims that happened in the same occurrence/incident. The $2,000,000 would be included in your yearly experience charge as it is paid by the Self-Insurance fund and it will apply to your claims experience. As of 1/1/21, the policy also has a $2,000,000 aggregate limit. This means upon reaching the aggregate loss fund (estimated at $2,645,997) and subject to a $500,000 loss limitation per claim, the plan would have an additional $2,000,000 in coverage for incurred claims cost.

The Plan this coverage annually. Therefore, for current limits and retentions, contact the Self-Insurance Dept.

Special Funds:

The New York State Special Funds Conservation Committee was established to provide relief for certain types of claims. The Special Funds assesses each carrier in New York each year to provide the monies for the Special Funds. This is usually a large expense of operating our own Self-Insurance Plan.

Special Disability Second Injury Fund: (Section 15-8 of the Workers' Compensation Law) Reimburses Self-Insurance Plan for medical and compensation awards for permanent disability or death after the first 260 weeks following a second injury or death. This fund applies only to injuries that occurred prior to 7/1/07 and has been closed to any new claims.

Special Disability Fund: (Section 14-6 of the Workers' Compensation Law) Reimburses Self-Insurance Plan for any additional benefits resulting from the increase in average weekly wages due to the employee's concurrent employments. This fund applies only to injuries that occurred prior to 7/1/07 and has been closed to new claims.

Fund for Reopened Cases: (Section 25a of the Workers' Compensation Law) Provides benefits for cases reopened after seven years from Date of Accident and three years since last indemnity payment. This fund was closed as of 1/1/14.

The Plan administration applies for these funds as appropriate to seek recoveries available. There are several other special funds for which we provide funding. However, those above are the most common.

Participant Assessments:

As a participant in the Self-Insurance Plan you are required to pay an annual assessment. The assessment calculation is governed by Warren County Local Law. Assessments are usually calculated during July of each year and provided to you for your following year's budget. The actual invoices are usually mailed just prior to January 1 of each year and payable as of that date.

Each participant is liable to pay its proportionate share of the cost of participation in the Plan, including administrative costs and expenses as determined using the following experience based formula:

Administrative Expenses will be allocated among the Plan Participants in the following way.

- Volunteer Ambulance Squads (for Volunteers) collectively will be charged 7% of the total Administrative Expenses. This cost will be allocated based upon the actual number of times a squad is dispatched by the Warren County Sheriff's Department during the last full year.
- Volunteer Fire Departments (for Volunteers) collectively will be charged 11% of the total Administrative Expenses. This cost will be allocated based upon the actual number of times a Department is dispatched by the Warren County Sheriff's Department during the last full year.
- All Participants with payroll will share the balance of the Administrative Expenses (82%) based upon actual gross payroll for the last full year.

Claims Expenses will be allocated among all Plan Participants based upon actual claims paid for the 8 full calendar years prior to the last January 1st. Each individual claim with a total paid for the sum of 8 years exceeding $50,000 will be charged $50,000.

Certificates of Insurance:

Occasionally proof of workers' compensation coverage requested from a municipality. The Warren County Self-Insurance Plan will provide evidence of coverage on an SI-105 form. Sample attached.

To request an SI-105 form, just contact the plan with the name and address of the entity requesting the form. We can send the form via email, fax or regular mail to the municipality or to the requesting entity.

STATE OF NEW YORK WORKERS'
COMPENSATION BOARD

CERTIFICATE OF PARTICIPATION IN WORKERS' COMPENSATION COUNTY SELF-INSURANCE PLAN

1a. Legal name and address of participant in County Self-Insurance Plan **1b. Effective date of membership in the Plan ____________.**	**1c. Telephone number of participant** **1d. NYS Unemployment Insurance Employer Registration Number of participant** **1e. Federal Employer Identification Number of participant**
2. Name and Address of the Entity Requesting Proof of coverage	**3. Name and address of County Self-Insurer** Warren County Self-Insurance 1340 State Rt 9 Lake George NY 12845

This certifies that the participant referenced above is complying with the mandatory coverage requirements of the New York State Workers' Compensation Law as a participating member of the County Self-Insurance Plan listed above and participation in such County Self-Insurance Plan is still in force. The County Self-Insurer's Administrator will send this Certificate of Participation to the ertificate holder listed in box 2.

If the membership of the participant listed in box 1a is terminated, the County Self-Insurer's Administrator will notify the certificate holder within 10 days of termination. (These notices may be sent by regular mail.) Otherwise, this certificate is valid for a maximum of one year from the date certified by the county self-insurer.

If this certificate is no longer valid according to the above guidelines and the participant referenced in box "1a" continues to be named on a permit, license or contract issued by the certificate holder, the participant must provide the certificate holder either with a new certificate or other authorized proof the participant is complying with the mandatory coverage requirements of the New York State Workers' Compensation Law.

The County Self-Insurer must file this certificate with the Workers' Compensation Board's Self-Insurance Office. (See reverse.)

Under penalty of perjury, I certify that I am an authorized representative of the County Self-Insurer referenced above and that the participant has the coverage as depicted on this form.

Certified by: ____________ VOID ____________
(Print name of authorized representative of County Self-Insurer)

Certified by: ____________ VOID ____________
(Signature) (Date)

Title: Insurance Administrator

Telephone Number: 518-761-6528

WORKERS' COMPENSATION LAW

Section 57 Restriction on issue of permits and the entering into contracts unless compensation is secured.

1. The head of a state or municipal department, board, commission or office authorized or required by law to issue any permit for or in connection with any work involving the employment of employees in a hazardous employment defined by this chapter, and notwithstanding any general or special statute requiring or authorizing the issue of such permits, shall not issue such permit unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that compensation for all employees has been secured as provided by this chapter. Nothing herein, however, shall be construed as creating any liability on the part of such state or municipal department, board, commission or office to pay any compensation to any such employee if so employed.

2. The head of a state or municipal department, board, commission or office authorized or required by law to enter into any contract for or in connection with any work involving the employment of employees in a hazardous employment defined by this chapter, notwithstanding any general or special statute requiring or authorizing any such contract, shall not enter into any such contract unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that compensation for all employees has been secured as provided by this chapter.

Please Note: This certificate is valid for a maximum of one year from the date this form is approved by the authorized representative of the County Self-Insurance Plan. After that date, if the participant continues to be named on a permit, license or contract issued by the above government entity, the participant must provide that government entity with a new certificate. The participant must also provide a new certificate upon notice of cancellation or change in status of such participation in the County Self-Insurance Plan.

The County Self-Insurer must file a copy of this certificate with the Workers' Compensation Board Self-Insurance Office at the address listed below.

Workers' Compensation Board
Self-Insurance Office-3rd Floor
328 State Street
Schenectady, NY 12305

SI-105.2P (1-13) Reverse

Industry Codes:

The C2F form requests industry codes. The NYS DOL form SH900.1 form also uses industry or "NAICS" codes.

These codes can be found at www.naics.com. Click on "code search" and input the general description of the type of work. Note that most municipalities will have several applicable codes depending on the type of work.

Some common codes that are used by municipalities are:

221310	Water treatment plant
237310	Highway construction
485111	Transit (Bus)
488119	Other airport operations
519120	Library
561730	Landscaping and grounds
562111	Transfer stations, Garbage pick up
611210	Community Colleges
621610	Home health care
621910	Ambulance services
623110	Skilled nursing facilities
623312	Assisted living facilities
624190	Individual and family services
921110	Executive government
921190	Other general government support
922120	Police
922130	Legal government
922140	Correctional institutions
922150	Probation
922160	Fire protection
923140	Veterans administration
924110	Government water and sewer
924120	Community recreation
925120	Community development, planning
926150	Building inspections

Workers' Compensation Class Codes:

Class codes are used by the insurance industry to apply rates used to calculate insurance premiums. Warren County does not use class codes for premium purposes. However, the C2F does request a "Manual Classification Code" on page 3 of 3. The Plan's excess insurance carrier also uses these codes to assess excess workers' compensation premiums.

We have developed the table below for use in assigning common class codes. The codes can also be researched on the website of the NY Compensation Insurance Rating Board at www.nycirb.org. Click on the "Classification Digest" under online tools.

WC Code	Titles Used For:
O106	**Tree Trimmer**
2591	**Laundry worker**
2883	**Cabinet Maker**
3365	**Welding**
5190	**Electrician**
5191	**Computer Installation**
5221	**Concrete or Cement work**
5507	**Highways** MEO, Working Supv, Laborer, Cement finisher, Recycling, foreman, dept hwy supv landfill employees, DPW drivers, railroad maint. HEO, Wingmen, hwy construction supv, (Hwy Superintendents are 9410)
6217	**Excavator and Grader drivers**
7370	**Vol Ambulance Operations**
7380	**Bus Drivers, Van Drivers** (Res hall, DSS, and towns)
7403	**Airport Operations**
7520	**Waterworks operations**
7580	**Sewage Plant Oper** Sewer operators Sewage electrical engineers sewer superintendent
7590	**Garbage Works -** Transfer Station (not curb pick-up)
7710	**Paid Firefighters**
7711	**Firefighters, Volunteer**
7720	**Police Officers** Sergeants, captains, detectives, police officer, security guards Corrections officers, probation officers Investigators, probation employees Town traffic control officers DA investigators, undersheriff, majors, chief deputy (civil officers are 8810, justice are 8820)
8385	**Garage Employees** DPW Mechanics, DPW inspectors DPW Storekeeper, auto shop supervisor
8394	**Paid Ambulance Workers**
8810	**Clerical and office** Traffic control assist, secretary/treas of VFD, transit dispatcher, purchasing, account clerks,

typist, police dispatcher, council members, real property clerks
business manager, laboratory tech, assessors, nutrition assists, budget officer at towns, zoning admin, bookkeeper
justice clerk, tax collector, historian, town supervisors, computer programmer, court officer, admin assist at hwys, water rent collector
civil law enforcement officers, auditor, voting system tech, deputy comm BOE, legislative office, mv lic reg clk, dpw accounting, DPW supt of buildings
public health educator, HR director, computer tech desk, IT employees, OFA employees not mealsite, transportation analyst, planning employees,
probation employees (not probation officers 7720), communications operators, social services clerical, e&t counselor, mental health clerical

8820 Attorneys & Judges
Assist Atty, Town Justice, Town Judge, legal clerks at County, (town legal clerks are 8810)
DA's, legal clerk at County clerk, DA employees, public defenders employees, DSS atty, DSS legal scty

8829 Nursing home & nurses
Health Services: PHN, RPN, CHN, Nurse tech, superv RN. (not director-9410)
Res Hall: Food Service, institutional aide, case manager, Cna, laborer, charge aide, activities director

8831 Veterinarian
-animal control officers

8832 Physician
- coroner

8838 Public Library
Library Professional Ees, Librarian, museum employees
Library Aide, library clerk, librarian

8854 Health Care Professionals
mental health director, health officers, PH liaison, WIC employees, medical records, Asst director HS,
Social Welfare examiners, heap, DSS caseworkers, support investigators, dire of admin serv at dss, dss administrator, comm DSS

8868 College Prof EE's (SUNY- teachers, teacher aides)

9015 Buildings - operations

9026 Buildings - commercial operations
town cleaners, DPW cleaners, custodians
coop ext housekeeping (maintenance are 9101) (Not college, they are 8868)

9063 Recreation Employees
co home activities aides
Recreation Dept EE's, Up yonda, program directors, lifeguards

9072 Food Prep
OFA Cooks, OFA mealsite manager, OFA food service help, res hall cook & dietary managers, wcsd cook (RH food serv is 8829)

9101 College Employees - All other (non-professional employees, cleaners, custodians, food prep.)

9102 Parks
Parks Supervisor, parks laborers, parks cleaners, parks supervisors (attends are 9063)

9220 Cemetery Operations

9402 Street or sewer cleaning

9403 Garbage Works - curb pick up

9410 Municipal EE's NOC
DPW Superintendents & HWY superintendents, Hwy engineers, trans director, code enforcement officers, zoning
Soil & water employees, building inspector, hatchery aide, DPW IT, E&T aids, DSS resource assist, DSS resource clerk, DSS resource coord

9552 Sign mfg/repair

FAQ (Frequently Asked Questions):

Do I need a lawyer?

Never advise your employee one way or another. It is the employees' (claimant) right to have a representative. The fee for the representative is deducted from the awards the claimant receives.

Does the employee get paid compensation to attend a hearing?

The employee (claimant) is only paid if disabled from working. Therefore if the claimant does not have any disability, they will not be paid for attending a hearing. It is up to you as the employer to determine the policy of leave time for that purpose.

Does the employee get paid mileage to attend a hearing?

No.

Does Workers' Compensation pay for over the counter medication?

Generally No. There are no provisions in the law covering over the counter medications like aspirin, ibuprofen, adhesive bandages and such.

How long does the employee have to notify their employer that they were injured?

Section 18 of the Workers' Compensation Law reads….."*Notice of an injury or death for which compensation is payable under this chapter shall be given to the employer within thirty days after the accident causing such injury….Such notice may be given by any person claiming to be entitled to compensation, or by someone in his behalf. The notice shall be in writing…"*
In cases of occupational disease Section 45 of the WCL reads…."*The requirements as to notice as to occupational disease and death resulting therefrom shall be the same as required in section eighteen of this chapter, except that the notice shall be given to the employer within two years after the disablement or after the claimant knew or should have known that the disease is due to the nature of the employment…."*

The employee paid for their prescriptions and is requesting reimbursement?

Warren County participates in the AWPRx pharmacy network. Employees are required to participate in the network. If they have paid for prescriptions they should return to the pharmacy that dispensed them with the AWPRx first fill sheet or pharmacy benefits card and ask the pharmacy to re-process the order.

Our employee broke their glasses at work, what do we do?

Glasses can be replaced under the Workers' Compensation Law. Claim reporting documents should be filed in the same way as any other injury. Employees can get the glasses replaced at any provider. The Workers' Compensation Law only provides for replacement. The provider can bill Warren County Self-Insurance by sending an itemized invoice or the employee can pay the fee and request reimbursement.

The employee returned to work after being out on Workers' Compensation, now they are back out of work again, what forms do I need to do?

There are no forms necessary to notify the Plan that the person is out of work again. Oftentimes the employee will present a work release slip from their health care provider to you, please forward a copy of this to the Plan just to give us the information. The Plan also requests that you let us know if leave time is being used and you are paying the employee. The Plan cannot make any payment until appropriate medical documents are received. See the section on C-11 for the form to file when the employee returns to work.

Where can an employee receive treatment?

The employee can go to any medical provider or chiropractor authorized by the New York State Workers' Compensation Board. However, the medical provider is sometimes limited to treatment allowed under the NYS WCB medical treatment guidelines.

Can the employee go out of state for treatment?

The employee can go out of state for treatment. However, the Plan pays medical providers based upon the New York State Workers' Compensation Board Fee Schedule, a provider authorized by the NYS Workers' Compensation Board accepts those fees as payment, an out of state provider may not accept the fees paid and bill the claimant for the balance.

I got injured 10 years ago and I still get the same rate of payment?

Yes, in NYS the Workers' Compensation Rate is based upon the year prior to the injury and under current regulation does not change.

The employee has only worked here for 3 weeks, what do we do to complete the C-240?

Refer to the section on Wage Statement. The C-240 would be completed using a comparable employee's salary that has worked a whole year.

NYS DOL PESH REPORTING:

The NYS DOL requires public employers to record workplace injuries. The forms involved are the Injury and Illness Incident Report(SH-900.2) ,Log of Work Related Injuries and Illnesses Form (SH900) and the Summary of Work-Related Injuries and Illnesses(SH900.1).

It is the Municipalities responsibility to assure that these forms are completed accurately and timely. However, Warren County will assist you with completing these forms and we provide periodic training for the same. Detailed information about the requirement is available from the NYS Department of Labor:

https://dol.ny.gov/system/files/documents/2021/03/901instruction.pdf

Note: some injuries and illness that occur in the workplace may not be covered by workers' compensation but would be reportable under the PESH regulation and visa versa.

Warren County will assist you with reporting if we can. If a case is filed that Self-Insurance believes is reportable under the NYS DOL PESH requirements, we will prepare and email to you a SH900.2 form when the workers' compensation claim received by our office. Additionally, we will send you a printout of the SH900 log showing the claims each month when there are new claims. At the end of the year we will send you a copy of the SH900.1 and the SH900. HOWEVER, these should be carefully reviewed and used as a tool to assist you in preparing the final copy. Warren County does not have all of the information and may not know all of the incidents and illness that occur in your work site. Nor do we know the various departments that you will need to complete individual reports for. Warren County does not take responsibility for the required reporting for the municipality we are only here as a resource.

NEW YORK STATE - DEPARTMENT OF LABOR
INJURY AND ILLNESS INCIDENT REPORT

FORM SH 900.2

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

This *Injury and Illness Incident Report* is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the *Log of Work Related Injuries and Illnesses* and the accompanying *Summary*, these forms help the employer and PESH develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out this form or an equivalent. Some state workers' compensation, insurance, or other reports may be acceptable substitutes. To be considered an equivalent form, any substitute must contain all the information asked for on this form.

According to 12NYCRR Part 801, PESH recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains.

If you need additional copies of this form, you may photocopy and use as many as you need.

Completed by ____________________

Title ____________________

Phone (___) ____________ **Date** ___/___/___

Employee Information:

1) Full name ____________________

2) Street ____________________

City ____________ State ____ Zip ________

3) Date of birth ___/___/___ 4) Date hired ___/___/___

5) ☐ Male ☐ Female

Physician/Health Care Professional Information:

6) Name of physician or other health care professional ____________________

7) If treatment was given away from the worksite, where was it given?

Facility ____________________

Street ____________________

City ____________ State ____ Zip ________

8) Was employee treated in an emergency room?
☐ Yes ☐ No

9) Was employee hospitalized overnight?
☐ Yes ☐ No

Information about the case:

10) Case number from the *Log* ____________________
(Transfer the case number from the Log after you record the case.)

11) Date of injury or illness ___/___/___

12) Time employee began work ________ AM / PM

13) Time of event ________ AM / PM

☐ Check if time cannot be determined

Event occurred ☐ before ☐ during ☐ after work shift

14) **What was the employee doing just before the incident occurred?** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials", "spraying chlorine from hand sprayer."

15) **What happened?** Tell us how the injury occurred. *Examples*: "When ladder slipped on wet floor, worker fell 20 feet", "Worker was sprayed with chlorine when gasket broke during replacement."

16) **What was the injury or illness?** Tell us the part of the body that was affected; be more specific than "hurt", "pain", or "sore." *Examples*: "strained back", "chemical burn, hand."

17) **What object or substance directly harmed the employee:** *Examples*: "concrete floor", "radial arm saw", "chlorine."

18) **If the employee died, when did death occur?** Date of death ___/___/___

ILLNESS CASES ONLY ☐ Check this box if the employee independently and voluntarily requests that his or her name not be entered on the log. If checked, treat as a privacy concern case.

Print Form

New York State
Department of Labor
Log of Work Related Injuries and Illnesses Form
SH-900

Political Subdivision (Employer) ____________
Establishment Name ____________
Street Address ____________
City ____________ State ______ Zip Code ______

Calendar Year 20 ____
Page ____ of ____

1. This form is required by the Commissioner of Labor's Rules and Regulations Part 801 (12 NYCRR Part 801) and must be kept in the establishment for five years. Failure to maintain this form can result in the issuance of a Notice of Violation and Order to Comply.
2. You must record information about every work-related death and about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injures and illnesses that meet any of the specific recording criteria found in 12 NYCRR 801.7 - 801.12 and instructions.
3. Use more than one line for a single case if necessary.
4. This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. Refer to the instructions (SH-901) for types of illness and injuries defined as privacy concern cases.

A. Case No.	B. Employee Name	C. Job Title	D. Date of Injury or Onset of Ilness (Mo./day)	E. Where the Event Occurred (e.g., Loading dock, north end)	F. Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (e.g., Second degree burns on right forearm from acetylene torch)	Using these categores, check ONLY the most serious result for each case.		Remained at Work		Enter No. of Days Injured or Ill Worker Was:		M. Check the Injury Column or Check One Type of Illness					
						G. Death	H. Days Away From Work	I. Job Transfer or Restriction	J. Other Recordable Cases	K. Away from Work	L. On Job Transfer or restriction	1. Injury	2. Skin Disorder	3. Respiratory Condition	4. Poisoning	5. Hearing Loss	6. All Other Illnesses
					TOTALS												

Additional forms and information: If you require additional forms or information concerning the completion of this form, contact: Department of Labor, Division of Research and Statistics, 75 Varick St., 7th Floor, New York, NY 10013. Telephone (212) 775-3344.

SH-900 (1-08)

STATE OF NEW YORK
DEPARTMENT OF LABOR

Divison of Safety and Health
Public Employee Safety and Health
State Office Campus
Building 12, Room 158
Albany, NY 12240

SUMMARY OF WORK-RELATED INJURIES AND ILLNESSES FORM SH-900.1

Calendar Year ___________

All establishments covered by PART 801 **must** complete this summary annually, even if no occupational injuries or illnesses occurred during the year.

Employees, former employees, and their representatives have the right to review this form. They also have limited access to the Log (SH 900) or its equivalent. See 801.35 and instructions for further details on access provisions for these forms.

1. ESTABLISHMENT INFORMATION	2. EMPLOYMENT INFORMATION
ESTABLISHMENT NAME	If you don't have accurate figures, see the instructions on the back of this sheet.
STREET ADDRESS	AVERAGE NUMBER OF EMPLOYEES ____________
CITY, STATE, ZIP CODE	
INDUSTRY DESCRIPTION (e.g.,village fire department)	TOTAL HOURS WORKED BY ALL EMPLOYEES LAST YEAR
NORTH AMERICAN INDUSTRIAL CLASSIFICATION SYSTEM (NAICS). ___ ___ ___ ___ ___ ___	____________

Enter the column totals from the Log of Occupational Injuries and Illnesses (SH 900) for each category (column labels under each line correspond to the columns on the Log). If a category has no cases, enter "0."

3. NUMBER OF CASES		4. NUMBER OF DAYS		5. INJURIES AND ILLNESS TYPES	
DEATHS	______ (Col. G)	AWAY FROM WORK	______ (Col. K)	INJURIES	______ (Col.1)
DAYS AWAY FROM WORK	______ (Col. H)	JOB TRANSFER OR RESTRICTION	______ (Col. L)	SKIN DISORDERS	______ (Col. 2)
JOB TRANSFER OR RESTRICTION	______ (Col. I)			RESPIRATORY CONDITIONS	______ (Col. 3)
OTHER RECORD-ABLE CASES	______ (Col. J.)			POISONINGS	______ (Col. 4)
				HEARING LOSS	______ (Col. 5)
				ALL OTHER ILLNESSES	______ (Col. 6)

6. CERTIFICATION

I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.

SIGNATURE ______________________________ TITLE ______________________________

PRINT NAME ______________________________ DATE ____________________

CALCULATING EMPLOYMENT INFORMATION (Section 2)

If accurate figures regarding the average number of employees and the total hours worked by your employees are not available, please use the steps below to estimate these numbers.

Average Number of Employees

1. Add the total number of employees paid in all pay periods for the year. Include all full-time, part-time, temporary, seasonal, salaried, and hourly employees. ____________ (a)

2. Count the number of pay periods for the year, including pay periods with no employees. ____________ (b)

3. Divide the number of employees by the number of pay periods. ________ / ________ (a / b) ____________ (c)

4. Round the answer to the next whole number. Enter this number in the line for "Annual average number of employees" in Item 2 on the front. ____________ (d)

Total Hours Worked By All Employees

1. Enter the number of full-time employees in your establishment for the year. ____________ (e)

2. Enter the number of work hours for a full-time employee in a year. ____________ (f)

3. Multiply (e) by (f) to find the number of full-time hours worked. **X** ____________ (g)

4. Add number of overtime hours and number of hours worked by other employees (part-time, temporary, seasonal). **+** ____________ (h)

5. Round the answer to the next highest whole number. Enter this number in the lines for "Total Hours Worked by All Employees Last Year" in Item 2 on the front. ____________ (i)

TIMELY REPORTING:

The NYS Workers' Compensation Board has instituted regulations regarding the timeliness of reporting employee injuries to the "carrier". In addition to the timely reporting requirements on the employer's side, the carriers are now under requirements to make payments to injured workers within the certain short time frames. This process is called "Payor Compliance". This process applies not only to employees but also to volunteer firefighters and volunteer ambulance workers.

The NYS WCB now issues monetary penalties to the carrier if the time frames are not adhered to. The penalties are issued to Warren County Self-Insurance. However, these penalties will be passed along to the participants in the Self-Insurance Plan. Thus, PAYOR COMPLIANCE IS VERY IMPORTANT AND MAY REQUIRE CHANGES IN YOUR REPORTING PROCESS.

The time frames for reporting injuries to the Self-Insurance Plan are all based on when your municipality, as the employer, knew of the injury. Timeliness is not at all based on when the employee filled out the form. For example, an employee is injured and tells their supervisor. That is the date the employer knew about the injury. If the supervisor doesn't tell the person that does the claim forms, it will not matter. The date that someone who supervises the employee knew of the injury is the important date.

"Disability Event" is a key definition in this process. "Disability Event" is basically defined as any accident occurring in the course of employment, which results in an injury causing the loss of time beyond the day of injury or requiring medical treatment.

Warren County Self-Insurance as your "carrier" must file a timely "First Report Of Injury" (FROI) via the Workers' Compensation Board electronic portal "on or before the18th day after the disability event OR within 10 days after the employer had knowledge of the disability event, whichever period is greater." This requirement is defined by NYCRR Section 300.22 and known as the "18/10" rule.

Warren County Self-Insurance as your "carrier" must also file a timely "Subsequent Report Of Injury" (SROI) via the Workers' Compensation Board electronic portal "on or before the 18th day after the disability event OR within 10 days after the employer had knowledge of the disability event OR within 10 days of when the claims administrator had knowledge of the disability event, whichever period is greater." This requirement is defined by WCL Section 25(2)(a) and known as the "18/10/10" rule.

Performance Standard:
Penalties will be issued if the "carrier" (WC SIF) does not meet the performance standards. The performance standard 85%. This standard will be periodically reviewed for possible adjustments. Fortunately, Warren County has a low number of reports. Unfortunately, one late report from a municipality can cause us to miss the performance standard and subject us to these penalties.

Penalties:
$50 for failure to file timely FROI within the "18/10" rule.

$50 for failure to file timely SROI and make payment to the injured worker within the "18/10" rule.

$300 for failure to file timely SROI and make payment to the injured worker within the 10 days of claims administrator knowledge, the "18/10/10" rule. This is in addition to the other penalties above.

20% of the amount due plus the amounts above if the carrier fails to pay the injured worker within 25 days of when payment was due.

What does this mean for the municipalities?

- Anyone that supervises workers MUST be aware of the importance of reporting employee injuries and getting the claim forms to Warren County Self-Insurance as soon as possible.
- Warren County may need to contact you for information sooner than in the past, i.e. a C240 payroll form as soon as we know the injured worker is out of work.
- The municipality should call Warren County Self-Insurance as soon as they know an employee will be out of work beyond the day of the injury. This will help us guide you through the process and help us set up the file for timely reporting.

Of note, in the past, we initiated payment to the injured worker upon receipt of medical evidence providing a causal relationship to the injury and a degree of disability. Under the current rules we must provide payment to the injured worker BEFORE we get the medical report relating the lost time to the injury. Thus if an employee informs you, the employer, that they are out of work due to the injury we must make payment based upon that information.

On the following two pages we have included fliers that you can copy and share with your management staff to help facilitate efficient claim reporting. “Employer Duties When Employees are Injured at Work” reviews the steps to take at each point in the process from when the injury occurs to when they return to work. “Claim Reporting Checklist for Employers” reviews the steps to make sure the Plan is notified and the claim forms are completed properly.

Warren County Self-Insurance

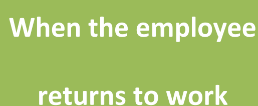
Employer Duties When Employees are Injured at Work

Employer must report injuries to Warren County Self-Insurance IMMEDIATELY by calling 518-761-6528 or by emailing claims@warrencountyny.gov. Report any information that is available, including name of employee, phone, injury description, type of medical care, lost time expected. Employers are deemed "notified" of an injury when the employees supervisor knows. This is the start of the countdown for all reports.

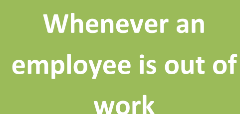
Employer must send claim forms regarding the injury to Warren County Self-Insurance within 10 days. Penalties for late filing will be assessed if claim documents are not timely. Claims can be emailed to claims@warrencountyny.gov

If the employee has missed time from work, employer must file C240 form and contact Warren County Self-Insurance to advise if the employee is using leave time or is off of the payroll.

Warren County Self-Insurance must ensure that payment is being made to the injured worker and file appropriate forms with the Workers' Compensation Board. Warren County must have accurate information from the Employer to do this. Penalties are assessed to the Employer for tardiness.



The Employer must share information with Warren County Self-Insurance immediately upon the employee's return to work. Employer must file C-11 form. If the employee used leave credits, employer must also file Reimbursement Request form.



Keep in regular contact with the injured worker. Request out of work notes to cover any time that they will not be at work. Share out of work information with Warren County Self-Insurance.

All forms and information can be sent to claims@warrencountyny.gov.
Questions: call 518-761-6528, 518-761-6529, or 518-824-6610.
We are here to help you!

Warren County Self-Insurance

Workers' Compensation

Claim Reporting Checklist for <u>EMPLOYERS</u>

Step 1: Call **518-761-6528** or email **claims@warrencountyny.gov** to report the claim as soon as the any member of management knows about it.

Step 2: Give the employee the claim packet and make sure to get it back as soon as possible to meet the 10-day filing requirement.

Before submitting claim documents to Warren County Self-Insurance, check that you have completed the steps below:

- ✓ Employee injury report has been completed and signed by the employee
- ✓ Employee has completed and signed the Authorization to Obtain Information
- ✓ The employee's supervisor has completed and signed the Supervisor's report
- ✓ C2-F has been completed in entirety
- ✓ Double check that all fields are completed on the C2-F
- ✓ Email all to claims@warrencountyny.gov no later than 10 days after injury date

Additional tasks if the employee is <u>out of work</u> due to the injury:

- Email claims@warrencountyny.gov that the employee is out of work and advise if the employee will be using leave time or will be off payroll
- Complete C-240 form and send with the forms above

<u>If you don't have all forms ready to send within 10 days, contact the Self-Insurance Plan at 518-761-6528.</u>