NEW YORK STATE | Workers' Compensation Board

VOLUNTEER AMBULANCE WORKER'S CLAIM FOR BENEFITS

SEE REVERSE FOR FILING INSTRUCTIONS

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

W.C.B. CASE NO. (if known)	CARRIER CASE NO. (if known)	CARRIER CODE NO.	DATE OF INJURY	SOCIAL SECURITY NO.

	First Name	Middle Initial	Last Name	Address (Give Number and Street, City, State, Zip Code)	Apt. No.
1. VOLUNTEER AMBULANCE WORKER					
2. AMBULANCE COMPANY					
3. POLITICAL SUBDIVISION					

INFORMATION, REGULAR WORK

4. (a) Marital Status _____ (b) Sex _____ (c) Date of Birth _____ (e) Tel. No. (___) _____

5. Describe in detail your duties in regular employment _____

6. Your work week at time of injury was (check one) ☐ 5 days ☐ 6 days ☐ 7 days ☐ Other _____

7. Employer's name and address _____

INJURY

8. (a) Were you injured in the line of duty in the jurisdiction of your own ambulance district or political subdivision? ☐ Yes ☐ No

(b) If you were injured in the line of duty involving assistance call from another locality, give name of other ambulance district or political subdivision _____

PLACE AND TIME

9. Address where injury occurred _____ County _____

10. Date of injury _____ at _____ o'clock _____ M

NATURE AND EXTENT OF INJURY

11. State full nature and cause of injury _____

12. Has injury resulted in amputation? ☐ Yes ☐ No If yes, describe _____

13. On what date did you stop work because of this injury? _____

14. Have you returned to work? ☐ Yes ☐ No If yes, give date _____

15. (a) Does injury keep you from work? ☐ Yes ☐ No (b) Have you done any work during your disability? ☐ Yes ☐ No

MEDICAL CARE

16. (a) Did you receive medical care? ☐ Yes ☐ No (b) Are you now receiving medical care? ☐ Yes ☐ No

17. (a) Are you now in need of medical care? ☐ Yes ☐ No (b) Name and address of attending doctor _____

18. If you were treated in a hospital, give name and address _____

VOLUNTEER AMBULANCE WORKERS' BENEFITS

19. Have you received volunteer ambulance workers' benefits payments for the injury reported above? ☐ Yes ☐ No

20. Are you now receiving volunteer ambulance workers' benefits payments? ☐ Yes ☐ No

21. Do you claim further volunteer ambulance workers' benefits payments? ☐ Yes ☐ No If yes, explain _____

NOTICE

22. Have you given Notice to Liable Pol. Subdivision of Vol. Ambulance Worker's Injury or Death (Form VAW-1) to the political subdivision liable for the payment of your vol. ambulance workers' benefits? ☐ Yes ☐ No If yes, was such Notice delivered personally? ☐ Yes ☐ No or sent by Registered Mail? ☐ Yes ☐ No If yes, to whom was Notice delivered/sent _____

_____ Date _____

Name of Officer and Political Subdivision

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO, OR BY AN INSURER, OR SELF INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

I certify that copy of this was filed with _____

Name of Officer Title of Officer

_____ on _____

Political Subdivision or Ambulance Service Liable for Benefits

Dated _____ Signed by _____ or

Volunteer Ambulance Worker

Signed _____

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

VAW-3 (1-11)

THIS CLAIM SHOULD BE FILED WITH THE CHAIR, WORKERS' COMPENSATION BOARD, AS SOON AS POSSIBLE AFTER INJURY IS INCURRED. DO NOT DELAY FILING THIS CLAIM.

WHAT EVERY VOLUNTEER AMBULANCE WORKER SHOULD KNOW IN CASE OF INJURY IN LINE OF DUTY

A. The law requires every county, city, town, village or ambulance district to:

1. Provide Volunteer Ambulance Workers' Benefits in case of accident or injury in the line of duty.
2. Post a notice of compliance:(a) Giving the name of the insurance carrier, if the community is insured, or (b) Stating that the community is self-insured. *(Look for this notice at your ambulance company headquarters. Advise the Workers' Compensation Board if it is not posted in a conspicuous place. Note: Ambulance Services unaffiliated with a political subdivision are not required to provide coverage under the VAWBL. However, if coverage is provided, a notice of compliance must be posted.)*

B. What You Must Do

1. You must give written notice of injury on Form VAW-1 or this Form VAW-3 by personal delivery or registered mail WITHIN NINETY DAYS after injury to the designated officer of the political subdivision liable for benefits as follows:

If the political subdivision liable for benefits is a	Then deliver to
a. County	a. Clerk of Board of Supervisors
b. City	b. Comptroller or Chief Financial Officer
c. Town	c. Town Clerk
d. Village	d. Village Clerk
e. Ambulance District	e. Secretary

   If a political subdivision is not liable for benefits, file this form with the head of the unaffiliated ambulance service. The home county, city, town, village or ambulance district is liable for the payment of benefits, regardless of whether service was rendered for the home area or for another area under contract or in response to a call for assistance.
2. Form VAW-1 is only a notice of injury or death and not a claim for benefits.
   In order to claim benefits, you must file this Form VAW-3 no later than two years after injury with: (a) Chair, Workers' Compensation Board (see address below) and (b) The same officer to whom a notice of injury was sent (item B1 above). If you file Form VAW-3 WITHIN NINETY DAYS, it serves as both a notice of injury and a claim for benefits, and you do not need to file Form VAW-1.
3. You should secure medical attention promptly (see item 2 below regarding choice of doctor).
4. Attend the hearing on your case if you are notified to appear before the Workers' Compensation Board.
5. Go back to work as soon as you are able.

C. Your Rights

1. As a volunteer ambulance worker, you are entitled to benefits if you suffer injury in the line of duty.
2. Generally, you are entitled to be treated by a doctor of your choice, provided he/she is authorized by the Board. If the ambulance service or political subdivision is involved in a preferred provider organization (PPO) arrangement, you must obtain initial treatment from the certified preferred provider organization which has been designated to provide health care services for volunteer ambulance workers' injuries.
3. You are entitled to be paid for drugs, crutches or any apparatus such as belts, if they are prescribed by your doctor; also for carfares and other necessary expenses going to and from your doctor's office or hospital. You are to secure a bill or receipt for such expenses and present it to the clerk of the county's board of supervisors, comptroller or chief financial officer of the city, clerk of the town or village, secretary of the ambulance district or to the ambulance service which is liable for providing volunteer ambulance workers' benefits, or its insurance carrier for payment. If payment is refused, the bill or receipt should be sent to the Workers' Compensation Board with a statement of fact that payment has been refused.
4. You are entitled to benefits from the first day of disability if your injury keeps you from work, compels you to work at lower wages, or leaves you with impaired eyesight or hearing, serious facial scars, or any permanent injury or stiffness of a finger, hand, toe, foot, leg or arm.
5. You are entitled to an opportunity to be heard on your claim before the Workers' Compensation Board.
6. You are entitled to the repair or replacement of prosthetic devices which are damaged as a result of services performed in the line of duty as a volunteer ambulance worker. Prosthetic devices include an artificial limb, artificial eye, eyeglasses, contact lens, hearing aid, denture or dental appliance or any surgical appliance required to be worn or used by the volunteer ambulance worker, but does not include articles considered to be ordinary wearing apparel.

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.

HIPAA NOTICE - In order to adjudicate a workers' compensation claim, WCL13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

INSTRUCTIONS: Claims should be sent directly to the Workers' Compensation Board at the address listed below:

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

Customer Service Toll-Free Line: 877-632-4996 **Statewide Fax Line: 877-533-0337**

IF YOU HAVE QUESTIONS OR NEED ADVICE ABOUT YOUR CLAIM, YOU MAY CALL OR VISIT THE NEAREST OFFICE OF THE WORKERS' COMPENSATION BOARD.	SI TIENE PREGUNTAS O NECESITA CONSEJO SOBRE SU RECLAMACION, PUEDE LLAMAR O VISITAR LA OFICINA DE LA JUNTA DE COMPENSACION MAS CERCANA A USTED.

BE SURE TO NOTIFY THE APPROPRIATE OFFICE OF THE WORKERS' COMPENSATION BOARD OF ANY CHANGE IN YOUR ADDRESS.