

STATE OF NY
WORKERS' COMPENSATION BOARD

VF/VAW ADJUSTMENTS

CARRIER'S REQUEST FOR BENEFIT INCREASE REIMBURSEMENT UNDER SECTION 51(2)
VOLUNTEER FIREFIGHTERS' & VOLUNTEER AMBULANCE WORKERS' BENEFIT LAWS

WCB Case No. _____

Carrier Case No. _____

Claimant _____

Social Sec. No. _____

Carrier: _____

Vol. Fire Claim () Vol. Ambulance Claim ()

Carrier Address: _____

Original weekly benefit rate in this claim: \$ _____ Increased benefit rate effective Jan. 1, 1999: \$ _____

The Carrier requests reimbursement for benefits paid, as follows:

A. Compensation/Death Benefits

_____ Weeks from _____ To _____ at \$ _____ /wk \$ _____

B. Lump Sum \$ _____

C. Re-marriage Award \$ _____

TOTAL OF THIS CLAIM FOR REIMBURSEMENT \$ _____

1. Does this represent an initial request for reimbursement in this claim? Yes () No ()

2. If this is the initial request for reimbursement, or re-marriage award, you must attach the following:

a. A copy of the Notice of Decision establishing the classification and benefit rate or award.

b. A copy of the form C-8/8.6 verifying the rate change.

Carrier Statement:

I hereby certify that this request for reimbursement made to the Chair of the Workers' Compensation Board is true and correct; that no part thereof has been previously paid and that the amount stated therein is due and owing.

By (Print or Type): _____ Telephone No. _____

Signature: _____ Title: _____ Date: _____

INSTRUCTIONS:

1. Claims for compensation reimbursement should be submitted for 52-week periods.
2. Forward original and one copy, along with any required documentation to:

WORKERS' COMPENSATION BOARD
FUND FOR REOPENED CASES UNIT - ROOM 312
20 PARK ST
ALBANY NY 12207

3. Retain one copy for your records.