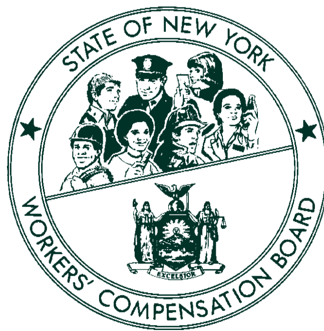
A GUIDE TO DISABILITY BENEFITS

Employee Benefits for Injuries and Illnesses that Occur off the Job in New York State



New York State Workers' Compensation Board
www.WCB.NY.Gov
1-800-353-3092

Privacy Statement

Any and all documents that you file with the Board, or that are filed with the Board in conjunction with your claim for benefits, are protected from disclosure, pursuant to Workers' Compensation Law §110-a.

Workers' Compensation Law §110-a prohibits the release of any of the information in your case file except to those who are party to your claim (including your employer, its disability insurance carrier, their attorney and your attorney), anyone to whom you have given written permission to access your claim information, or anyone who has obtained a court-order authorizing them to access your claim information. Your information may be shared with other government entities in order for them to process claims for benefits or investigate fraud. Finally, your health care providers may have access to portions of your claim file, in order that they may ascertain payment for services.

The law also prohibits anyone from re-disclosing your information to anyone who is not authorized to have access to it.

You can authorize another person or entity to access to your claim file information in two ways:

> By submitting an original Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records; or
>
> By submitting an original notarized letter or form indicating your authorization that a particular person or entity may have access to your claim information.

You may submit your authorization at any time during the course of your compensation claim. Providing a copy of the authorization to the person to whom you have granted authorization will always help that person obtain access. Some people choose to submit an OC-110A form when they initially file for benefits, authorizing their spouse or child to access their case file information on their behalf.

Prospective employers may not ask you for information about disability claims before hiring you.

The Workers' Compensation Board does not discriminate on the basis of race, color, national origin, sex, religion, age, disability or sexual preference, in employment or the provision of service.

What Are Disability Benefits?

Disability benefits are temporary cash benefits paid to an eligible wage earner, when that person is disabled by an off-the-job injury or illness. The Disability Benefits Law provides weekly cash benefits to replace, in part, wages lost due to injuries or illnesses that do not arise out of or in the course of employment. Disability benefits are also paid to an unemployed worker to replace unemployment insurance benefits lost because of illness or injury.

An employer is allowed, but not required, to collect contributions from its employees to offset the cost of providing benefits. An employee's contribution is computed at the rate of one-half of one percent of wages, but no more than sixty cents a week.

If an employee has more than one job at the same time, with combined wages of more than $120 per week, the employee may request each employer to adjust the contributions in proportion to the earnings of each employment. The combined contributions may not exceed 60 cents per week. The request should be made as soon as the employee enters a second job.

Disability benefits include cash payments only. Medical care is the responsibility of the claimant. It is not paid for by the employer or insurance carrier.

DISABILITY BENEFITS PLANS

Employers may provide benefits under a Disability Benefits Plan, or one negotiated by agreement and accepted by the Chair of the Workers' Compensation Board, under the Disability Benefits Law. Benefits (rate, duration and waiting period) are payable as provided by the plan. The employer may pay the entire cost of the plan. In some plans, employees are required to contribute more than 60 cents per week, but only by agreement and provided the employees' contributions are reasonably related to the value of the benefits. If employees must contribute, the employer must contribute the balance of the cost of the insurance.

Who is Covered?

- Employees or recent employees of a "covered" employer, who have worked at least four consecutive weeks. (An employer of one or more persons on each of 30 days in any calendar year becomes a "covered" employer four weeks after the 30th day of such employment.)
- Employees of an employer who elects to provide benefits by filing an Application for Voluntary Coverage.
- Employees who change jobs from one "covered" employer to another "covered" employer are protected from the first day on the new job. Generally, eligible employees do not lose protection during the first 26 weeks of unemployment, provided they are eligible for and claiming unemployment insurance benefits.
- Domestic or personal employees who work 40 or more hours per week for one employer.

Who is Not Covered?

- A minor child of the employer.
- Government, railroad, maritime or farm workers.
- Ministers, priests, rabbis, members of religious orders, sextons, Christian Science readers.
- Corporate officers and persons engaged in a professional or teaching capacity in or for a religious, charitable, or educational institution of a "non-profit" character, and persons receiving rehabilitation services in a sheltered workshop operated by such institutions under a certificate issued by the U.S. Department of Labor.
- Persons receiving aid from a religious or charitable institution, who perform work in return for such aid.
- One or two corporate officers who either singly or jointly own all of the stock and hold all of the offices of a corporation that employs no other employees.
- Golf caddies.
- Daytime students in elementary or secondary school, who work part-time during the school year or their regular vacation period.
- Employees who change to jobs in an exempt employment or with a "non-covered" employer, and work in such employment for more than four weeks, lose protection until they work four consecutive weeks for a "covered" employer.

Note: A "noncovered" employer may elect at any time to provide disability coverage by filing an Application for Voluntary Coverage with the Chairman of the Workers' Compensation Board.

Cash Benefits

Cash benefits are 50 percent of a claimant's average weekly wage, but no more than the maximum benefit allowed. The average weekly wage is based on the last eight weeks of employment. If counting the last week in which the disability began lowers the benefit rate, it is not included in determining average weekly wage. The maximum benefit allowance for any disability is $170 a week. Benefits paid by the employer or insurance carrier are subject to Social Security and withholding taxes.

Benefits are paid for a maximum of 26 weeks of disability during 52 consecutive weeks. For employed workers, there is a 7-day waiting period for which no benefits are paid. Benefit rights begin on the eighth consecutive day of disability.

For unemployed workers who are receiving Unemployment Insurance benefits and who become disabled more than four weeks (but within 26 weeks) after termination of employment, benefits are payable from the first day of the disability that disqualifies them from receiving Unemployment Insurance benefits. An employer must supply a worker who has been disabled more than seven days with a Statement of Rights under the Disability Benefits Law (form DB-271), within five days of learning that the worker is disabled.

This pamphlet is a general and simplified presentation of Disability Benefits provisions of the Workers' Compensation Law. It is not a substitute for the law or legal advice.

How to File a Claim

- If you are currently employed, or if you have been unemployed for less than four weeks from the date the disability began, file the claim with your employer or insurance carrier, using form DB-450. There is a copy in the center of this pamphlet, or you may obtain a copy from the nearest district office. **Keep a copy of this form to submit again if your claim is not paid promptly.**

- If you have been unemployed more than four weeks from the date the disability began, file the claim with the Disability Benefits Bureau, using the form DB-300. Mail it to the address at the end of this pamphlet.

- You must file your claim within 30 days after you become disabled. If you file late, you will not be paid for any disability period more than two weeks before the claim is filed. Late filings may be excused if it is shown that it was not reasonably possible to file earlier. No benefits will be paid if you file more than 26 weeks after your disability begins.

- You must be under the care of a physician, chiropractor, podiatrist, psychologist, dentist, or certified nurse midwife in order to qualify for benefits. Your health care provider must complete and sign the *Health Care Provider's Statement* as proof of your disability.

- However, if you depend for healing upon prayer through spiritual means alone in the practice of religion, you must be under the care of a duly accredited practitioner to qualify for benefits. In this situation, the practitioner must complete and sign the "Practitioner's Statement" (form DB-450.5) before mailing.

- Before filing your claim, be sure that you have completed and signed the "Claimant's Statement" and your health care provider or practitioner has completed and signed his/her portion. **Submit this information promptly to avoid delaying your claim.**

Common Questions About Disability Benefits

Q. What is a *day of disability*?
A. A *day of disability* is one when the employee was prevented from working because of disability, and he does not receive regular wages or remuneration.

Q. If an employee engages in work for remuneration or profit, even if done at home, while disabled, is she eligible for disability benefits?
A. No. As long as she performs any kind of work for remuneration or profit, she is ineligible for benefits.

Q. Are the costs of medical care included?
A. No. Costs of medical care are not included under the statutory provisions of the Disability Benefits Law. However, where an employer or a union or association plan has been accepted as complying with the law, the worker is entitled to the benefits as described by the plan. Contact your employer to find out if it provides or participates in such a plan.

Q. May an employer/insurance carrier have an employee claiming benefits examined by a health care provider it designates?
A. Yes. The employee must submit herself at intervals, but not more than once a week, to such examinations if requested. Exams are not paid for by the employee and are held at a reasonable time and place. Refusal to submit to an exam may jeopardize a claimant's benefits.

Q. After a claim is filed, how soon will it be paid?
A. If a claim is properly completed with the required statements, the first payment should arrive within four business days after the 14th day of disability or four business days after the receipt of the claim, whichever is later. Benefits are payable every two weeks during the period of disability.

Q. Can a claimant collect Unemployment Insurance and Disability Benefits for the same period of time?
A. No.

Q. If an employee quits his job, can that employee receive Disability Benefits?
A. Voluntary termination of employment unrelated to the disability **may** affect an employee's right to Disability Benefits.

Q. Can a claimant collect Disability Benefits for disability caused by pregnancy?
A. Yes. If she is disabled because of pregnancy, she may be entitled to up to 26 weeks of benefits. Disability can occur at any time during pregnancy.

Q. What determines disability due to pregnancy?
A. Disability can only be determined and certified by a physician or certified nurse midwife, with medical reports. If a claimant is disabled more than four to six weeks prior to the anticipated birth date, or is disabled more than four to six weeks after the actual birth date, more detailed information regarding the disability may be required. The medical reports should describe specific symptoms, rather than just general prognosis. **Note:** An elective sterilization procedure will not extend the payable period of disability, since benefits are not payable for any period an individual is unable to work due to elective surgery.

Q. Can an employee collect disability benefits if on maternity leave?
A. Yes. If she is on a leave of absence without pay (i.e. maternity leave), and becomes disabled within four weeks of the last day she actually worked, she is entitled to benefits from the employer/carrier (if otherwise eligible). If the disability begins more than four weeks from the last day actually worked and she is claiming/receiving Unemployment Benefits, she is entitled to disability benefits from the Special Fund for Disability Benefits (if otherwise eligible).

Q. Is there a limit on the number of weeks a claimant can receive benefits?
A. Yes. There is a limit of 26 weeks of benefits during a period of 52 consecutive calendar weeks or during any one period of disability. The amount of benefits a claimant receives is dependent upon how long he is actually disabled, as certified by a physician. (If an employer has a separate Disability Benefits Plan, more than 26 weeks of benefits may be paid, if so specified).

Q. What if a claimant is still disabled, but benefits have stopped?
A. If she received less than 26 weeks of benefits, is still disabled, and has not received a Notice of Rejection, she must submit further medical evidence to her employer, insurance carrier or the Special Fund for Disability Benefits. If she has received a Notice of Rejection, the claimant may request a review of the rejection by completing its reverse side and mailing it to the Disability Benefits Bureau at the Workers' Compensation Board.

Q. Is a claimant entitled to Disability Benefits for an injury incurred in an auto accident?
A. Yes. However, the amount of the disability benefits may reduce any no-fault insurance benefits the claimant is eligible to receive.

Q. If a claim is rejected or not paid, may it be reviewed?
A. Yes. If a claim is rejected or not paid, the employee should complete the reverse side of the Notice of Rejection (sent by the employer/carrier/the Special Fund, within 45 days of its receipt of the claim) and mail it within 26 weeks to the Disability Benefits Bureau. The address is located on the back of the rejection notice, and in the back of this brochure. Where necessary, the Board will obtain further information and may hold a hearing on the claim. **Benefits will be paid if a claim is determined proper and valid.**

Q. If a claimant is entitled to or receiving Social Security Retirement Benefits, may he still receive Disability Benefits?
A. Yes. If he is entitled to Disability Benefits, the fact that he is eligible for or receiving old-age insurance benefits under the Social Security Act does not affect his right to Disability Benefits.

Written inquiries should be sent to:
Disability Benefits Bureau
Workers' Compensation Board
100 Broadway-Menands
Albany, NY 12241

Disability Benefits Offices

1-800-353-3092

Albany District Office
100 Broadway - Menands
Albany, NY 12241

Binghamton District Office
State Office Building
44 Hawley Street
Binghamton, NY 13901

Brooklyn District Office
111 Livingston Street
Brooklyn, NY 11201

Buffalo District Office
Ellicott Square Building
295 Main Street - Suite 400
Buffalo, NY 14203

Hauppauge District Office
220 Rabro Drive, Suite 100
Hauppauge, NY 11788-4230

Hempstead District Office
175 Fulton Avenue
Hempstead, NY 11550

Manhattan District Office
215 W. 125th Street
New York, NY 10027

Peekskill District Office
41 North Division Street
Peekskill, NY 10566

Queens District Office
168-46 91st Avenue
Jamaica, NY 11432

Rochester District Office
130 Main Street West
Rochester, NY 14614

Syracuse District Office
935 James Street
Syracuse, NY 13203

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

CLAIMANT: READ THE FOLLOWING INSTRUCTIONS CAREFULLY

1. USE THIS FORM IF YOU BECOME SICK OR DISABLED **WHILE EMPLOYED** OR IF YOU BECOME SICK OR DISABLED **WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT**. USE CLAIM FORM **DB-300** IF YOU **BECOME SICK OR DISABLED AFTER HAVING BEEN UNEMPLOYED MORE THAN FOUR (4) WEEKS**.
2. YOU MUST COMPLETE ALL ITEMS OF PART A - THE **"CLAIMANT'S STATEMENT"**. BE ACCURATE. CHECK ALL DATES.
3. BE SURE TO DATE AND SIGN YOUR CLAIM (SEE ITEM 12). IF YOU CANNOT SIGN THIS CLAIM FORM, YOUR REPRESENTATIVE MAY SIGN IT IN YOUR BEHALF. IN THAT EVENT, THE NAME, ADDRESS AND REPRESENTATIVE'S RELATIONSHIP TO YOU SHOULD BE NOTED UNDER THE SIGNATURE.
4. **DO NOT MAIL THIS CLAIM UNLESS YOUR HEALTH CARE PROVIDER COMPLETES AND SIGNS PART B - THE "HEALTH CARE PROVIDER'S STATEMENT."**
5. YOUR COMPLETED CLAIM SHOULD BE MAILED **WITHIN THIRTY (30) DAYS AFTER YOU BECOME SICK OR DISABLED TO YOUR LAST EMPLOYER OR YOUR LAST EMPLOYER'S INSURANCE COMPANY.**
6. MAKE A COPY OF THIS COMPLETED FORM FOR YOUR RECORDS BEFORE YOU SUBMIT IT.

PART A - CLAIMANT'S STATEMENT (Please Print or Type) ANSWER ALL QUESTIONS

Social Security Number ☐☐☐ ☐☐ ☐☐☐☐

1. My name is...
   First Middle Last
2. Address...
   Number Street City or Town State Zip Code Apt. No.
3. Tel. No.. 4. Date of Birth .... 5. Married (Check one) ❑Yes ❑No
6. My disability is (if injury, also state how, when and where it occurred) ....

   ....
7. I became disabled on .... a. I worked on that day ❑ Yes ❑No
   Month Day Year

   b. I have since worked for wages or profit. ❑ Yes ❑ No If "Yes", give dates ....
8. Give name of last employer. If more than one employer during the last eight (8) weeks, name all employers.

EMPLOYER'S			DATES OF EMPLOYMENT		AVERAGE WEEKLY WAGES (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	FROM	THROUGH	
			Mo. Day Yr.	Mo. Day Yr.	

9. My job is or was ....
   Occupation Name of Union and Local Number, if Member
10. For the period of disability covered by this claim
    a. Are you receiving wages, salary or separation pay: .... ❑ Yes ❑ No
    b. Are you receiving or claiming:
       (1) Workers' compensation for work-connected disability.. ❑ Yes ❑ No
       (2) Unemployment Insurance Benefits... ❑ Yes ❑ No
       (3) Damages for personal injury .... ❑ Yes ❑ No
       (4) Benefits under the Federal Social Security Act for long-term disability .... ❑ Yes ❑ No

    IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 10a OR 10b, COMPLETE THE FOLLOWING:
    I have ❑ received ❑ claimed from .... for the period .... to........................
    Date Date
11. I have received disability benefits for another period or periods of disability within the 52 weeks immediately before my present disability began .... ❑ Yes ❑ No
    If "Yes", fill in the following: I have been paid by ....From .... To ....
    Date Date
12. I have read the instructions above. I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled; and that the foregoing statements, including any accompanying statements, are to the best of my knowledge true and complete.

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.

Claim signed on ....
Date Claimant's Signature

If signed by other than claimant, print below: name, address, and relationship of representative.

....

Disclosure of Information: The Board will not disclose any information about your case to any unauthorized party without your consent. If you choose to have such information disclosed to an unauthorized party, you must file with the Board an original signed Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records, or an original signed, notarized authorization letter. You may telephone your local WCB office to have Form OC-110A sent to you, or you may download it from our web page, www.wcb.ny.gov. It can be found under the heading Common Forms Online. Mail the completed authorization form or letter to the address given below.

IF YOU HAVE ANY QUESTIONS ABOUT CLAIMING DISABILITY BENEFITS, CONTACT THE NEAREST OFFICE OF THE NYS WORKERS' COMPENSATION BOARD, OR WRITE TO: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, NY 12241-0005

SI TIENE DUDAS RELACIONADAS CON LA RECLAMACIÓN DE BENEFICIOS POR INCAPACIDAD, COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA DE COMPENSACION OBRERA DE NUEVA YORK, O ESCRIBA A: WORKER'S COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY- MENANDS, ALBANY, NY 12241-0005

HEALTH CARE PROVIDER MUST COMPLETE PART B ON REVERSE

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

IMPORTANT: USE THIS FORM ONLY WHEN THE CLAIMANT BECOMES SICK OR DISABLED **WHILE EMPLOYED OR** BECOMES SICK OR DISABLED **WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT**. OTHERWISE USE CLAIM FORM DB-300.

PART B - HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type)

THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY AND THE FORM MAILED TO THE INSURANCE CARRIER OR SELF-INSURED EMPLOYER, OR RETURNED TO THE CLAIMANT WITHIN SEVEN DAYS OF THE RECEIPT OF THE FORM. For item 7d, give approximate date. Make some estimate. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date under "Remarks".

1. Claimant's Name .... 2. Date of Birth .... 3. Sex ❑ Male ❑ Female
4. Diagnosis/Analysis .... Diagnosis Code.................
   a. Claimant's Symptoms ....
   ....
   ....
   b. Objective Findings ....
   ....
5. Claimant Hospitalized? ❑ Yes ❑ No From .... To ....
6. Operation Indicated? ❑ Yes ❑ No a. Type .... b. Date ....
7. Enter Dates for the Following:

	Month	Day	Year
a. Date of your first treatment for this disability			
b. Date of your most recent treatment for this disability			
c. Date claimant was unable to work because of this disability			
d. Date claimant will be able to perform usual work			

   (Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease? ❑ Yes ❑ No
   If yes, has form C-4 been filed with the Workers' Compensation Board? ❑ Yes ❑ No
   Remarks (attach additional sheet, if necessary) ....
   (If disability is pregnancy related, please enter estimated delivery

I affirm that I am a	❑ Chiropractor ❑ Dentist	❑ Physician ❑ Podiatrist	❑ Psychologist ❑ Nurse-Midwife	Licensed in the State of	License Number

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.

Health Care Provider's Signature .... Date ....
Health Care Provider's Name (Please Print) .... Tel.No. ....
Office Address ....
Number Street City or Town State Zip

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.

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

DOWNSTATE CENTRALIZED MAILING
(for New York City, Hempstead, Hauppauge & Peekskill Districts)
PO Box 5205 Binghamton, NY 13902-5205
NYC (800)877-1373 / Hemp. (866)805-3630 / Haup. (866)681-5354 / Peek. (866)746-0552

100 Broadway Menands ALBANY 12241 (866) 750-5157	State Office Building 44 Hawley Street BINGHAMTON 13901 (866) 802-3604	295 Main Street Suite 400 BUFFALO 14203 (866) 211-0645	130 Main Street W. ROCHESTER 14614 (866) 211-0644	935 James St. SYRACUSE 13203 (866) 802-3730

State of New York
WORKERS' COMPENSATION BOARD

CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS

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

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

Claimant's Name	Claimant's Social Security No.	Case Number ❑WCB ❑DB ❑Discrimination and/or Date of Accident

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

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

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 case(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

____, at
Name of a Specific Person, Corporation, Association or Public or Private Entity

____.
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 ballpoint pen 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.

Pursuant to Workers' Compensation Law Section 110-a:

3. Individual authorization. Notwithstanding the restrictions on disclosure set forth under subdivision one of this section, a person who is the subject of a workers' compensation record may authorize the release, re-release or publication of his or her record to a specific person not otherwise authorized to receive such record, by submitting written authorization for such release to the board on a form prescribed by the chair or by a notarized original authorization specifically directing the board to release workers' compensation records to such person. However, in accordance with section one hundred twenty-five of this article, no such authorization directing disclosure of records to a prospective employer shall be valid; nor shall an authorization permitting disclosure of records in connection with assessing fitness or capability for employment be valid, and no disclosure of records shall be made pursuant thereto. It shall be unlawful for any person to consider for the purpose of assessing eligibility for a benefit, or as the basis for an employment-related action, an individual's failure to provide authorization under this subdivision.

4. It shall be unlawful for any person who has obtained copies of board records or individually identifiable information from board records to disclose such information to any person who is not otherwise lawfully entitled to obtain these records.

5. Any person who knowingly and willfully obtains workers' compensation records which contain individually identifiable information under false pretenses or otherwise violates this section shall be guilty of a class A misdemeanor and shall be subject upon conviction, to a fine of not more than one thousand dollars.

6. In addition to or in lieu of any criminal proceeding available under this section, whenever there shall be a violation of this section, application may be made by the attorney general in the name of the people of the state of New York to a court or justice having jurisdiction by a special proceeding to issue an injunction, and upon notice to the defendant of not less than five days, to enjoin and restrain the continuance of such violations; and if it shall appear to the satisfaction of the court or justice that the defendant has, in fact, violated this section, an injunction may be issued by such court or justice, enjoining and restraining any further violation, without requiring proof that any person has, in fact, been injured or damaged thereby. In any such proceeding, the court may make allowances to the attorney general as provided in paragraph six of subdivision (a) of section eighty-three hundred three of the civil practice law and rules, and direct restitution. Whenever the court shall determine that a violation of this section has occurred, the court may impose a civil penalty of not more than five hundred dollars for the first violation, and not more than one thousand dollars for the second or subsequent violation within a three year period. In connection with any such proposed application, the attorney general is authorized to take proof and make a determination of the relevant facts and to issue subpoenas in accordance with the civil practice law and rules.