State of New York
WORKERS' COMPENSATION BOARD
APPLICATION FOR APPROVAL OF NON-SCHEDULE ADJUSTMENT
(Please Type All Answers)

We, the undersigned, jointly apply for Board approval that this claim be closed on a non-schedule adjustment

____ Section 15, Subdivision 5-b, Workers' Compensation Law
____ Section 12, Volunteer Firefighters' Benefit Law
____ Section 12, Volunteer Ambulance Workers' Benefit Law

in the amount of $.. Claimant's Soc. Sec. No. ....

W.C.B. Case No. .... Carrier Case No. ....

District Office of Hearing ....
Carrier

....vs ....
Claimant Employer

1. Date of accident .... 2. Date of application .... 3. Claimant's date of birth ....

4. Accident, Notice, Causal Relation established for: [site(s) of injury or occupational disease] ....

5. Claimant is at present employed by ....
Employer

a. Address of employer ....

b. Weekly earnings $.................................. c. First date of such employment ....

6. List ALL sources of income and amounts, other than Workers' Compensation benefits ....

....

7. Number and birth dates of persons dependent on the claimant for support...

8. a. Is claimant married? ☐Yes ☐No b. If married, is spouse employed? ☐Yes ☐No c. If spouse is employed, what are his/her weekly earnings? $...................... 9. Amount of monthly rent or mortgage $....................................

10. Is case closed? ☐Yes ☐No a. Date of closing .... b. Date of classification ....

11. Last award was from .... to .... at $........................... weekly (reduced earnings)

12. Total Compensation paid to date $............................ (attach Form C-8/8.6) a. Claimant's Average Weekly Wage $.................................... (as set in the Workers' Compensation case)

b. If claimant was under 25 years old on the date of the accident, was wage expectancy ruled upon? ☐Yes ☐No

13. Therapeutic report of Dr. .... (attach report in ALL cases of causally related mental condition only) dated ....

14. Name of claimant's ☐Attorney or ☐Licensed Representative (check one) ....

15. Fee requested $.............................. (attach Form OC-400.1) b. Total prior fees $......................... c. Are any fees unpaid? ☐Yes ☐No

16. Is claimant receiving medical treatment? (for causally related disability) ☐Yes ☐No Give date of last compensable treatment................................ (See Note 1(b) on reverse)

17. Have all medical bills for past treatment been paid? ☐Yes ☐No If No, are medical bills being controverted for reasons which require resolution by a Workers' Compensation Law Judge? ☐Yes ☐No

18. Are there any issues pending before the Workers' Compensation Law Judge on: a. 15(8)? ☐Yes ☐No

b. 25-a? ☐Yes ☐No c. Overpayment? ☐Yes ☐No d. Apportionment? ☐Yes ☐No e. Are there any other unresolved issues? ☐Yes ☐No If yes, list unresolved issues ....

19. Is a related action pending against a third party or a question of deficiency compensation not yet resolved? ☐Yes ☐No

20. If there are outstanding issues, can they be resolved by stipulation? ☐Yes ☐No If yes, list those issues that can be resolved by stipulation(s)

21. Is there currently a child support lien on Workers' Compensation benefits ordered by the Family Court? ☐Yes ☐No If yes, has the Support Collection Unit of your County been notified of this settlement? ☐Yes ☐No (Attach written agreement from the Support Collection Unit of your County to the terms of this proposed settlement.)

22. Does the claimant currently reside in New York State? ☐Yes ☐No If No, will he or she be present at the non-schedule adjustment hearing? ☐Yes ☐No If No, interrogatories must be submitted with this form together with an UP-TO-DATE MEDICAL REPORT. (See Note 1(c) on reverse.)

23. Is an interpreter needed for the lump sum hearing? ☐Yes ☐No If yes, indicate language required: ....

24. Give complete details of the claimant's plan for use of the proceeds of the adjustment, if and when approved by the Board. (Use additional sheets, if necessary, and attach to this form.) ....

....

....

25. Does the claimant fully understand that if the adjustment is approved, his/her case is closed and cannot, under the Workers' Compensation Law, be reopened unless the Board shall find that the claimant's disability related to his/her Workers' Compensation case has changed for the worse in condition or in the degree of disability not found in the medical evidence and, therefore, not contemplated at the time of the lump sum? ☐ Yes ☐ No

26. Does the claimant fully understand that, pursuant to the Workers' Compensation Law, in the event of such reopening, the insurance carrier or self-insured employer will receive credit for the entire amount of the non-schedule adjustment and that payments will not resume until the entire amount is absorbed, even if the claimant is disabled?

    ☐ Yes ☐ No

27. Does the claimant fully understand that any future medical bills will be his/her responsibility and that other forms of medical insurance may not be liable for future medical treatment related to the compensable disability?

    ☐ Yes ☐ No

NOTE

1. This application may be rejected without a hearing if:
   a. All questions are not answered.
   b. Claimant has received causally related medical care within the twelve months prior to the date of this application. In such case, a medical report indicating that the claimant no longer requires active treatment must accompany this application or be contained in the Board file.
   c. Interrogatories and a detailed medical report (diagnosis, current condition, and discharge from further treatment) for out-of-state claimants who will not attend the hearing do not accompany this application. Interrogatories must be completed within 90 days and medical report within 30 days of submission of the application.
2. Under the federal law, 42 USC Section 424a(b), any offset of the claimant's social security disability benefit may continue even after a lump sum payment of workers' compensation benefits "to the extent that it is a commutation of, or substitute for, periodic payments." Claimants who are receiving city, state or federal benefits of any type should consult the appropriate agencies to determine what effect, if any, this proposed settlement will have on their benefits.

We, the undersigned, hereby certify the above statements to be true and agree to this offset of the claim for the stated purpose and, in reliance on the facts above set forth, jointly request approval by the Board.

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.

Claimant	Representative of Insurance Carrier or Self-Insured
Present Address	Telephone Number
Representative of the Special Funds Cons. Comm.	Claimant's Attorney or Licensed Representative (specify)
Date signed	Telephone Number

This application can be considered ONLY IF ALL INFORMATION IS FULLY STATED and the application has all of the above required signatures. When COMPLETED and SIGNED by ALL PARTIES, this application should be SENT DIRECTLY to the Board's address below:

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

Statewide Fax Line: (877) 533-0337

The Board requires investigation of the facts and, in some cases, vocational or medical advice in connection with each application before action is taken. After this investigation is completed, if your application is in order, you will be notified of the date, time and place when a hearing will be held. When the decision is made, you will receive written notice of the decision of the Board.

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.

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

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.