

**CARRIER'S REQUEST FOR REIMBURSEMENT OF COMPENSATION PAYMENTS
UNDER SEC. 14-6 CONCURRENT EMPLOYMENT**

WCB CASE NO.	CARRIER CASE NO.	CARRIER ID NO. W	SOC. SEC. NO.
CARRIER'S NAME		CARRIER'S ADDRESS	
CLAIMANT'S NAME			

The Carrier requests reimbursement for benefits paid, as follows:

A. _____ weeks from _____ to _____ at \$ _____ \$ _____

_____ weeks from _____ to _____ at \$ _____ \$ _____

_____ weeks from _____ to _____ at \$ _____ \$ _____

B. Lump sum payment representing _____ weeks at \$ _____ per week. \$ _____

C. Other (Specify) _____ \$ _____

TOTAL CLAIM FOR REIMBURSEMENT \$ _____

1. Does this claim represent an initial request for reimbursement of compensation payments? Yes No
If yes, attach Notice of Decision establishing average weekly wage and concurrent employment.
2. Attach copies of all claimant status checks.
3. Form SROI-SA MUST also be submitted.

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 the amount stated therein is due and owing.

Signature: _____ Date: _____

Title: _____ Telephone No.: _____

INSTRUCTIONS:

1. Where possible, claim should be submitted for 26 week periods.
2. Forward one copy to the local office of the Special Funds Conservation Committee.
3. Forward original and one copy to Workers' Compensation Board, 328 State Street, Schenectady, NY 12305, ATT: FINANCE OFFICE.
4. Retain one copy.