



## Discharge or Discrimination Compliant

Mail completed form to: Discrimination Unit • Riverview Center - 150 Broadway • Menands, NY 12204

### TYPE OF BENEFIT CLAIM

☐ Disability Benefits (Off-the-Job Disability)

Social Security #: \_\_\_\_\_

☐ Workers' Compensation (On-the-Job Injury)

WCB Case # (For On-the-Job Injury): \_\_\_\_\_

**PLEASE PRINT OR TYPE. ANSWER ALL QUESTIONS - FAILURE TO DO SO MAY DELAY PROCESSING OF YOUR COMPLAINT  
ANSWER QUESTIONS 6 AND 7 IN DETAIL - ATTACH ADDITIONAL SHEETS IF NECESSARY**

***SUBMIT IN DUPLICATE TO THE ADDRESS AT THE TOP OF THIS FORM.***

1. Employee Name: \_\_\_\_\_

2. Employee Address: \_\_\_\_\_

3. Employer Name: \_\_\_\_\_

4. Employer Address: \_\_\_\_\_

5. Were you discharged: ☐ Yes ☐ No If "Yes", give date: \_\_\_\_\_

6. State in detail the basis for your complaint, the reason you were dismissed and the name of your supervisor or manager or person who actually dismissed you:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. State the name(s) of others involved. Attach a copy of your dismissal notice, if any, or other documents received: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

8. Where did you work (Indicate address, if different than item 4 above): \_\_\_\_\_

\_\_\_\_\_

9. Occupation: \_\_\_\_\_

10. Name and address of your attorney or representative, if any (see statement "On Representation" on reverse): \_\_\_\_\_

\_\_\_\_\_

11. Date of accident or first day of disability: \_\_\_\_\_

**I AFFIRM UNDER PENALTY OF PERJURY THAT THE INFORMATION PROVIDED HEREIN IS TRUE:**

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone Number

## WORKERS' COMPENSATION LAW

**Sec. 120. Discrimination against employees who bring proceedings.** It shall be unlawful for any employer or his or her duly authorized agent to discharge or in any other manner discriminate against an employee as to his or her employment because such employee has claimed or attempted to claim compensation from such employer, or because he or she has testified or is about to testify in a proceeding under this chapter and no other valid reason is shown to exist for such action by the employer.

Any complaint alleging such an unlawful discriminatory practice must be filed within two years of the commission of such practice. Upon finding that an employer has violated this section, the board shall make an order that any employee so discriminated against shall be restored to employment or otherwise restored to the position or privileges he or she would have had but for the discrimination and shall be compensated by his or her employer for any loss of compensation arising out of such discrimination together with such fees or allowances for services rendered by an attorney or licensed representative as fixed by the board. Any employer who violates this section shall be liable to a penalty of not less than one hundred dollars or more than five hundred dollars, as may be determined by the board. All such penalties shall be paid into the state treasury. All penalties, compensation and fees or allowances shall be paid solely by the employer. The employer alone and not his or her carrier shall be liable for such penalties and payments. Any provision in an insurance policy undertaking to relieve the employer from liability for such penalties and payments shall be void.

An employer found to be in violation of this section and the aggrieved employee must report to the board as to the manner of the employer's compliance within thirty days of receipt of a final determination. In case of failure to report on compliance, or failure to comply with an order or penalty of the board within thirty days after the order or notice of penalty is served, except where timely application to the board for a modification, rescission or review of such order or penalty has been filed under section twenty-three of this chapter, the chair in any such case or on the chair's consent, any party may enforce the order or penalty in a like manner as an award of compensation.

**Sec. 241. Application of other provisions of chapter.** All the powers and duties conferred or imposed upon the chairman and board by this chapter that are necessary for the administration of this article and not inconsistent are, to that extent, hereby made applicable to this article; and none of the other provisions of this chapter pertaining to benefits provided by other articles of this chapter shall be construed to be applicable to this article. The provisions of section one hundred twenty of this chapter shall be applicable as fully as if set forth in this article, except that penalties paid into the state treasury pursuant thereto under this article shall be applied toward the expenses of administering this article.

### ON REPRESENTATION

While you are not required to obtain anyone to represent you in connection with a discrimination complaint, you have the right to be represented by an attorney or licensed representative, if you so choose. If you are represented by an attorney or licensed representative in your workers' compensation or disability benefits case, and wish to be represented by him/her, please contact him/her to determine whether or not he/she will represent you. If not, you have the right to select another representative of your choice.

#### **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 NEED HELP COMPLETING THIS FORM, OR IF YOU HAVE ANY OTHER QUESTIONS,  
CONTACT ANY OFFICE OF THE WORKERS' COMPENSATION BOARD.**