State of New York - Workers' Compensation Board

CLAIM FOR VOLUNTEER AMBULANCE WORKERS' BENEFITS IN A DEATH CASE

This claim will be processed more quickly if copies of necessary documents are submitted to the Board. Attach copies of the documents which you have in your possession. Otherwise obtain copies and bring them to the first hearing. DO NOT DELAY filing this claim form. Necessary documents are as follows:

a. A medical report from doctor who treated the deceased.
b. Death certificate.
c. Proof of relationship such as birth certificate, marriage certificate, adoption papers, etc.
d. Itemized funeral bill.

Does this claim involve disease or malfunction of the heart or of one or more coronary arteries? ☐ Yes ☐ No

W.C.B. CASE NO. (if known)	CARRIER CASE NO.	CARRIER CODE NO.	DECEDENT'S SOC. SEC. NO.	CLAIMANT'S SOC. SEC. NO.	DATE OF ACCIDENT

	NAME	ADDRESS (Give No, Street,City, State and Zip Code)	Apt. No.
DECEASED VOLUNTEER AMB. WORKER			
AMBULANCE COMPANY			
POLITICAL SUBDIVISION LIABLE			
CARRIER			
CLAIMANT			Apt. No.

I hereby make claim for death benefits payable under the Volunteer Ambulance Workers' Benefit Law for injury to the deceased volunteer ambulance worker named above sustained in the line of duty and in support of this claim, I submit the following information:

1. a. Death occurred on (Date)_____at (Place)_____
(Attach Death Certificate If Available)

b. Date of injury _____at_____o'clock_____M.

c. Address and community where injury occurred _____

d. Was volunteer ambulance worker injured in the line of duty in the jurisdiction of his/her ambluance district or political subdivision? ☐ Yes ☐ No

If volunteer ambulance worker was injured in the line of duty involving an assistance call from another locality, give name of other ambulance district or political subdivision _____

e. Cause of injury (Describe fully what factors or events led up to or contributed to the injury.)_____

_____

f. Nature of injury and part of body injured_____

Note: Attach a medical report, if available.

	Name	Address
2. ATTENDING PHYSICIAN		
3. LAST PHYSICIAN OR HOSPITAL		
4. UNDERTAKER		
5. PERSON WHO PAID UNDERTAKER BILLS		

6. Amount of Undertaker's Bills $ _____ Amount paid, if any $_____ (Attach funeral bill, if available.)

7. Claimant's date of birth _____ 8. Relationship to deceased_____

9. Is deceased survived by a spouse and/or children under 18 years of age or under 25 years of age and enrolled and attending as full-time students in any accredited educational institution? ☐ Yes ☐ No

10. Survivors or dependents of the deceased - attach additional sheet if necessary (SEE INSTRUCTIONS ON REVERSE SIDE)

Name	Address	Birth Date	Relationship

NOTE: Attach proof of relationship such as birth certificate, marriage certificate, adoption papers, etc., if available.

IF YOU HAVE ANY QUESTIONS ABOUT CLAIMING DEATH BENEFITS, CONTACT THE NEAREST OFFICE OF THE WORKERS' COMPENSATION BOARD.	SI TIENE ALGUNAS PREGUNTAS RESPECTO A COMO RECLAMAR BENEFICIOS POR MUERTE, COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA DE COMPENSACION OBRERA.

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

11. IF YOU ARE THE SPOUSE OR CHILD OF THE DECEASED ENTER THE FOLLOWING INFORMATION AS APPLICABLE:

a. You were married to the deceased on (date) _____ at (place) _____
by (person performing ceremony) _____ Attach marriage certificate if available.

b. Number of children under 18 years of age at the time of the death of the deceased. _____

c. Number of children at least 18 years of age but under 25, enrolled and attending as full time students in any accredited educational institution at the time of the death of the deceased. _____

12. IF YOU ARE NEITHER THE SPOUSE OF THE DECEASED OR CHILD OF THE DECEASED UNDER 18 YEARS OF AGE OR UNDER 25 YEARS ENROLLED AND ATTENDING AS A FULL TIME STUDENT IN ANY ACCREDITED EDUCATIONAL INSTITUTION, ENTER THE FOLLOWING INFORMATION:

a. Were you wholly or partially dependent on the deceased for your support? _____

b. If partially dependent, to what degree? _____

c. I own property as follows: (1) Real estate, assessed value $_____, from which I receive an income of $_____ annually and on which there is an indebtedness of $ _____.

(2) What other sources of income do you have? (Name each source and give amounts derived from each source named.)

SOURCE AMOUNT

13. IF YOU ARE A CHILD OR DEPENDENT GRANDCHILD, DEPENDENT BROTHER OR DEPENDENT SISTER, AT LEAST 18 YEARS OF AGE BUT UNDER 25 AND ENROLLED AND ATTENDING AS A FULL TIME STUDENT IN ANY ACCREDITED EDUCATIONAL INSTITUTION, ENTER THE FOLLOWING INFORMATION AND ATTACH CERTIFICATION OF ATTENDANCE, IF AVAILABLE FROM SUCH INSTITUTION.

Name of Student	Name & Address of Educational Institution	Date Attendance Began

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.

I certify that copy of this claim was filed with _____
(Name of Officer)

_____ _____ on _____
(Title of Officer) (Political Subdivision Liable for Benefits)

Dated _____ Signed by _____ _____ **or**
(Claimant's Signature) Telephone No.

Signed by _____ _____ _____
(A person on behalf of claimant) (Relationship) Telephone No.

TO THE CLAIMANT

1. This claim for Death Benefits (Form VAW-62) must be filed within two years after death with the Chairman, Workers' Compensation Board at address shown below, AND the designated officer to whom the notice of injury or death must be given as follows:

If the political subdivision liable for benefits is a	*Then deliver to*
a. County	a. Clerk of the Board of Supervisors
b. City	b. Comptroller or Chief Financial Officer
c. Town	c. Town Clerk
d. Village	d. Village Clerk
e. Ambulance District	e. Secretary

The home county, city, town, village, or ambulance district is liable for the payment of benefits for injuries, regardless of whether service was rendered for the home area, or for another area under contract or in response to a call for assistance.

2. If the deceased's ambulance service was not affiliated with a political subdivision, file this form with the head of the unaffiliated ambulance service.
3. Under the Volunteer Ambulance Workers' Benefits Law, "persons" who may be eligible to claim death benefits include only the following:
   a. Widow or widower;
   b. Children who were under the age of 18 at the time of death;
   c. Children of any age who were totally blind or physically disabled at the time of injury and whose disablement is total and permanent;
   d. Grandchildren and brothers and sisters of the deceased who were under the age of 18 at the time of death and wholly or partially dependent upon the deceased for support at the time of injury;
   e. Parents and grandparents of the deceased who were wholly or partially dependent upon the deceased for support at the time of injury;
   f. Effective July 1, 1976, children and dependent grandchildren, dependent brothers and dependent sisters under 25 years of age who are enrolled as full time students in any accredited educational institution.
4. Each claimant must file a separate claim except that only one claim need be filed by a spouse and/or children of the deceased under age 18 or under 25 and enrolled as full time students in any accredited educational institution.
5. Section 40 of the Volunteer Ambulance Workers' Benefit Law requires that unless a claim for death benefits has been filed WITHIN NINETY DAYS after death, a written notice of death shall be given to the designated officer of the political subdivision or unaffiliated volunteer ambulance service liable for benefits by personal delivery or by registered mail within said ninety day period. Form VAW-1 has been prescribed for this purpose. Form VAW-1 is not a claim for death benefits. Form VAW-62, Claim for Death Benefits, if filed within ninety days after death, serves also as Notice of Death in place of Form VAW-1.

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.

Claims should be sent to the Workers' Compensation Board at the address listed below:

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