SROI - IP, AP, PD, CD, EP, RB, ER

PRINT CARRIER NAME HERE

NOTICE TO CHAIR OF CARRIER'S ACTION ON CLAIM FOR BENEFITS

DN0004 DN0058, DN0059 DN0058, DN0059

CHECK TYPE OF CASE: ☐ WORKERS' COMPENSATION ☐ VOLUNTEER FIREFIGHTER ☐ VOLUNTEER AMBULANCE WORKER

ANSWER ALL QUESTIONS FULLY - TYPEWRITER OR COMPUTER PREPARATION IS REQUIRED

ALL COMMUNICATIONS SHOULD REFER TO THESE NUMBERS		3. Carrier Code	4. Date of Injury	5. Social Security Number
1. WCB Case Number	2. Carrier Case Number			
DN0005	DN0015	DN0006	DN0031	DN0042, DN0270

	Name	Address to which notices should be sent
6. Injured Person	DN0043, DN0044, DN0045, DN0255	DN0046, DN0047, DN0048, DN0049, DN0050, DN0155
7. Employer*	DN0016, DN0018	DN0165, DN0166, DN0167, DN0168, DN0169, DN0170
8. Carrier	DN0006, DN0007	DN0010-DN0014, DN0136, DN0137, DN0188

*In volunteer firefighters' and volunteer ambulance workers' cases, enter the liable political subdivision (or unaffiliated ambulance service as defined in VAWBL) as the EMPLOYER

9. Description (Diagnosis) of injury DN0035, DN0036, DN0037, DN0038

10. Place where injury occurred (city/county/state) DN0118, DN0119, DN0120, DN0121, DN0122, DN0123

11. Date disability began..... DN0056

12. Date employer or carrier first had knowledge of injury, whichever is earlier.... DN0040, DN0041

13. Date of receipt by carrier of employer's report of injury (C-2, VF-2 or VAW-2) (If none, so state).....

14. Date returned to work (if applicable)..... DN0068, DN0072

DN0074=I DN0075 with "L" (with liability)

15. A. ☐ **CLAIM IS NOT DISPUTED. PAYMENT HAS BEGUN.** Complete items 1 and 2 below if either 15-A or 15-B is checked.

B. ☐ **TEMPORARY PAYMENT OF COMPENSATION AND PRESCRIBED MEDICINE HAS BEGUN WITHOUT PREJUDICE AND WITHOUT ADMITTING LIABILITY (Sec. 21-a WCL)** DN0075 with "W" (without liability)

1. Payment has begun from DN0088 at a weekly rate of $ DN0134 Date first payment mailed DN0195

☐ Check here if weekly rate shown is a temporary rate subject to adjustment upon receipt of payroll information and complete section 2 below.

If the rate is less than the maximum in effect on the date of the injury (WCL 15, subd. 6(a)), the basis for the computation MUST be entered in item 2 *and supporting documents (payroll or other) MUST be attached.* DN0172, DN0174, DN0175

2. **Basis For Computation - Workers' Compensation Cases Only**

Average Daily Wage $_____ x _____ = $ _____ -:- 52 = Average Weekly Wage

$_____ x 2/3 = Weekly Comp. Rate (Subject to Maximum) If temporary rate indicate basis_____

Check here if payment made without prejudice, as provided in Sec.50 VFBL/VAWBL, pending determination of political subdivision/vol. ambulance service liable for benefits ☐ DN0058 or DN0059 and DN0085

Death Cases: attach list of payees, showing name and ad dress, relationship to deceased, date of birth, percentage of award and rate per week for each payee, if known. Also include name and address of undertaker, amount of funeral bill, amount of funeral bill paid and by whom (name and address). DN0097, DN0217

16. ☐ **CLAIM IS NOT DISPUTED. PAYMENT HAS NOT BEGUN FOR FOLLOWING REASON(S):** DN0074 = M

a. ☐ No lost time beyond 7 days. (In volunteer firefighters' and ambulance workers' cases, 7 day waiting period does not apply.)

b. ☐ Lost time exceeds 7 days, no medical evidence indicating disability beyond 7 days. (When such evidence is available, carrier must commence payment.)

c. ☐ Possible schedule loss or disfigurement, but no loss of time from work at regular wages beyond 7 days. DN0074 = M

d. ☐ Lost time exceeds 7 days, but full wages being paid by employer during disability.

☐ Employer requests reimbursement in the amount of $_____ for the period DN0273 to _____

e. ☐ Death case awaiting information as to dependents, if any, or dependency proofs - accidental death not controverted. SROI-CD: DN0055, DN0146

f. ☐ Other SROI-PD: DN0197,DN0074 DN0294

17. Designated carrier employee (*see NYCRR 325-1.4*) who receives requests for authorization of special medical services costing more than $1,000:

Name _____ Telephone No. _____

The insurance company will notify the Chair, Workers' Compensation Board, and the claimant and his/her representative, if any, if benefits are stopped or modified, or of any other change in the above information.

Prepared by DN0140 Dated DN0003

Official Title DN0138, DN0139 Telephone No. & Extension DN0137

This notice must be filed with the CHAIR, Workers' Compensation Board, by the Insurance Company or Self-Insured Employer at the office of the district in which the injury occurred. IF PAYMENT (INCLUDING TEMPORARY PAYMENT WITHOUT PREJUDICE) HAS BEGUN, this form must be filed on or before the 18th day after disability, or within 10 days after the employer first had knowledge of the injury, whichever period is greater. IF PAYMENT HAS NOT BEGUN, this form must be filed no later than 25 days after the Board has mailed the notice of indexing of a case. *A copy of this notice must also be mailed to the CLAIMANT, to his or her REPRESENTATIVE, if any, and to ALL HEALTH PROVIDERS treating the claimant, at the same time it is filed with the Chair.*

TO THE CLAIMANT

This notice shows that your employer or its insurance company has **either:**

a. **If Item 15-A is checked** -- started to pay benefits to you without waiting for an award by the Workers' Compensation Board,

or b. **If Item 15-B is checked** -- started to pay temporary benefits to you without admitting liability for your claim.

or c**. If Item 16 is checked** -- does not now dispute the injury described on the other side of this form, but has not begun to pay benefits for the reasons shown.

IF PAYMENT HAS BEGUN (Item 15-A), payment of benefits will be made to you, generally every two weeks, at the rate shown on the other side of this notice. Payments will continue until your employer or its insurance company notifies you and the Board, on Form C-8/8.6, that such payments are being stopped or modified for reasons which will be stated on the form. The Board will then notify you in writing of any further action taken in your claim.

In order to avoid delays in payment, the insurance carrier may sometimes use a temporary compensation rate until payroll information is obtained from the employer. Later, when the proper rate is established, prior payments may have to be adjusted. The weekly rate at which payments are made is always reviewed by the Board.

IF TEMPORARY PAYMENT HAS BEGUN (Item 15-B), payments may continue for up to one year or until your employer or its insurance company notifies you and the Board, on Form C-8/8.6, that such payments are being stopped. The Board will then notify you in writing of any further action taken in your claim. **This payment is not an admission of liability by the employer for your injury or injuries**. You may be required to enter into an agreement with the employer to ensure continuation of payment of temporary compensation.

IF PAYMENT HAS NOT BEGUN (Item 16), the reason(s) for non-payment will be indicated on the front of this notice. The Board will review your claim to determine if any benefits are payable to you. The Board may schedule a hearing or meeting to resolve outstanding issues. Permanent defects or disfigurements are usually evaluated six months to one year after an injury and may require your appearance at the Board.

You are entitled to compensation if your injury keeps you from work more than one week (with loss of wages); forces you to work at lower wage; or leaves you with permanently injured eyesight or hearing, serious facial scars, or any permanent defect in a finger, hand, toe, foot, leg or arm. In volunteer firefighters' and volunteer ambulance workers' cases, you are entitled to benefits if your injury keeps you from work for even one day.

Do not pay any doctor or hospital bills in connection with your injury. All medical bills should be sent to your employer or its insurance company. If you, or your private health insurer, have spent money for medicine, drugs, transportation or medical bills relating to your injury, you are entitled to reimbursement. Send bills or receipts for these expenses to your employer or its insurance carrier. If you are not reimbursed, advise the Board.

The Law permits the employer or its insurance company to have its doctors examine you periodically at a reasonably convenient place. You may be asked to submit to such an examination from time to time. You are allowed to have your own doctor present at these examinations if you wish. If you refuse to be examined, your benefits may be stopped or reduced.

VOLUNTEER AMBULANCE WORKERS AND VOLUNTEER FIREFIGHTERS

In volunteer ambulance workers' and volunteer firefighters' benefit cases, the liable political subdivision (or unaffiliated ambulance service as defined in the Volunteer Ambulance Workers' Benefit Law) is considered the "employer," with respect to the information given above.

BE SURE TO NOTIFY THE WORKERS' COMPENSATION BOARD AND THE INSURANCE COMPANY OF ANY CHANGE IN YOUR ADDRESS

IF YOU HAVE ANY QUESTIONS CONCERNING THIS NOTICE OR YOUR CASE, OR WITH RESPECT TO YOUR RIGHTS UNDER THE WORKERS' COMPENSATION LAW, OR THE VOLUNTEER FIREFIGHTERS', VOLUNTEER AMBULANCE WORKERS' OR DISABILITY BENEFITS LAWS, YOU SHOULD CONSULT THE NEAREST OFFICE OF THE BOARD FOR ADVICE. **ALWAYS USE THE CASE NUMBERS SHOWN ON THE OTHER SIDE OF THIS NOTICE**, OR ON OTHER PAPERS RECEIVED BY YOU, IF YOU FIND IT NECESSARY TO WRITE OR CALL THE BOARD.

SI USTED TIENE DUDAS EN RELACIÓN A ESTA NOTIFICACIÓN O SOBRE SU CASO, O EN RELACIÓN A SUS DERECHOS BAJO LA LEY DE COMPENSACIÓN OBRERA, O LAS LEYES DE BENEFICIOS DE LOS BOMBEROS VOLUNTARIOS O DE LOS VOLUNTARIOS DE CUERPOS DE AMBULANCIA, O LAS LEYES DE BENEFICIO POR INCAPACIDAD, DEBE ASESORARSE CON LA OFICINA DE LA JUNTA MAS CERCANA. CUANDO SE COMUNIQUE CON LA JUNTA **CITE SIEMPRE LOS NÚMEROS DE CASOS QUE APARECEN AL DORSO**, O EN LOS OTROS DOCUMENTOS QUE HAYA RECIBIDO.

TO THE CARRIER: Section 114 of the Workers' Compensation Law provides, in part, that any employer or carrier, or any employee, agent, or person acting on behalf of an employer or carrier, who knowingly makes a false statement or representation as to a material fact for the purpose of avoiding provision of any payment or benefit under this chapter shall be guilty of a felony.

WORKERS' COMPENSATION BOARD DISTRICT OFFICES

DOWNSTATE CENTRALIZED MAILING
(for New York City, Hempstead, Hauppauge & Peekskill Districts)
PO Box 5205 Binghamton, NY 13902-5205
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(866) 750-5157

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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