



To the claimant: Additional information regarding the electronic *Request for Further Action by Insurer/Employer (Form RFA-2)* can be found on the Board's website www.wcb.ny.gov under the eForms page.

CASE INFORMATION		
WCB Case ID 55555555	Date of Injury 01/01/2020	Claim Admin Claim # 555

Claimant Name Fake, Case

Employer Name NYS WCB Fake Case Primary Employer

Insurer Name WCB Test Insurer Attn: Michael [REDACTED]

Insurer ID [REDACTED]

Claim Admin Name WCB Test Insurer Attn: Michael [REDACTED]

Claim Admin ID [REDACTED]

RFA-2 SUBMITTED ON BEHALF OF

Insurer Name: WCB Test Insurer Attn: Michael [REDACTED]

Insurer ID: [REDACTED]

Employer Name: NYS WCB Fake Case Primary Employer

Claim Admin Name: WCB Test Insurer Attn: Michael [REDACTED]

Claim Admin ID: [REDACTED]

Submitter Firm Name: [REDACTED]

Representative ID: [REDACTED]

RFA-2 SUMMARY

Summary of selected request reason(s):

1. Payments directed by the Board should be suspended pursuant to §300.23(b)

Additional proposed findings:

1. No additional proposed findings

RFA-2 REQUEST DETAILS

1. Payments directed by the Board should be suspended pursuant to §300.23(b)

Decision that directed continuing payments (see table below)

Form ID	Document ID	Received Date
EC-23	[REDACTED]	[REDACTED]

See suspension reason(s) listed below:

--- Suspension Reason: Medical evidence finds no disability or fails to support ongoing disability (see table below)

Form ID	Medical Provider Name	Medical Service Date	Document ID	Received Date
C-107			[REDACTED]	[REDACTED]

SUPPORTING DOCUMENTATION

Referenced Document(s):

Form ID	Medical Service Date	Document ID	Received Date
EC-325-O1K		[REDACTED]	[REDACTED]

CERTIFICATION

The following request(s) require certification:

1. Payments directed by the Board should be suspended pursuant to §300.23(b)

I certify that I have discussed the reason(s) selected with the opposing party(ies) or its representative(s) and no settlement

CERTIFICATION

could be reached.

First Name	Last Name	Organization/Individual Name	Date
Joe	Tester	Claimant/Beneficiary	01/29/2026

ATTESTATION

I affirm that:

- (1) my statements are true and correct, and
- (2) I am authorized to submit this request, and
- (3) this request for Board action is based upon reasonable grounds and that this form with attachment(s) has been provided to the opposing party(ies), and
- (4) I accept that the electronic submission of this form to the Workers' Compensation Board is equivalent to placing my signature on the request.

Submitter Name: Jane Tester**Email:** test@test.com**Date:** 01/30/2026**Phone Number:** 5555555555 **Ext.:**