NEW YORK STATE Workers' Compensation Board

REQUEST FOR FURTHER ACTION BY INSURER/EMPLOYER
RFA-2

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	Date of Injury	Claim Admin Claim #
55555555	01/01/2020	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 reduced pursuant to §300.23(b)

2. Request disqualification pursuant to §114-a

Additional proposed findings:

1. Establish average weekly wage (AWW)

RFA–2 REQUEST DETAILS

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

Decision that directed continuing payments (see table below)

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

Continuing payments directed by the Board should be reduced to: $500.00

--- Reduction reason: Medical evidence finds a change in disability (see table below)

Form ID	Medical Provider Name	Medical Service Date	Document ID	Received Date
EC-325-MG2	[redacted]		[redacted]	[redacted]

2. Request disqualification pursuant to §114-a

List of documents or evidence to be produced: Document A, Document B

ADDITIONAL PROPOSED FINDINGS

1. Establish average weekly wage (AWW)

Primary employer average weekly wage (AWW): $1500.00

AWW calculation method used: Per payroll using 260 multiple

Are you raising concurrent employment? Yes

ADDITIONAL PROPOSED FINDINGS

Concurrent Employer Name	AWW for Concurrent Employer	AWW Calculation Method	Other Method
ABC Corp	$2000.00	Per similar worker payroll using 260 multiple	

SUPPORTING DOCUMENTATION

Referenced Document(s):

Form ID	Medical Service Date	Document ID	Received Date
EC-16.1		[redacted]	[redacted]

CERTIFICATION

The following request(s) require certification:

1. *Payments directed by the Board should be reduced pursuant to §300.23(b)*
2. *Additional Proposed Findings: Establish average weekly wage (AWW)*

I certify that I have discussed the reason(s) selected with the opposing party(ies) or its representative(s) and no settlement 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 **Date:** 01/30/2026

Email: test@test.com **Phone Number:** 5555555555 **Ext.:**