

To the Claimant - General Information On Using This Form

You may file this form (ERFA-1W) with the Workers' Compensation Board when you want the Board to take a specific action in your claim, or if you need to alert the Board to any problem or situation that is affecting your claim. Many of the most frequently requested actions/situations are listed as either compensation payment issues (items a through g), or medical issues (items h through l), but you are not limited to those listed. Check all that apply and/or add additional information or explanation in the space provided (m or n).

Complete the requested information on Form ERFA-1W and submit the form, WITH ALL APPLICABLE INFORMATION ATTACHED*. The Board will contact you and all parties when it takes action on your claim.

**After each checkbox you will see the information needed in italicized letters. For example, if you are letting the Board know that your disability is now permanent (box j), the information required is, (Attach Form C-4.3 Doctor's Report of MMI/Permanent Impairment.).*

YOU MUST SEND A COPY OF THIS FORM TO THE INSURER (CLAIM ADMINISTRATOR).

If you have any other concerns, you may contact the Board's **ADVOCATE FOR INJURED WORKERS at 1-800-580-6665**. Additional information about other Board services may be obtained at the Board's website: www.wcb.ny.gov. If you would like to follow your claim on-line, you can register for eCase using the registration instructions available on the Board's website under the eCase link.

You have the right to legal representation. A lawyer cannot charge you directly for representation in a workers' compensation claim. If there is an award in your claim, any legal fee request must be approved by the Board and will be deducted from the award to you by the insurance carrier and paid directly to the lawyer.

Para el reclamante: información general sobre el uso del presente formulario

Puede presentar este formulario (ERFA-1W) ante la Junta de Compensación Obrera en caso de que desee que la WCB tome una medida específica respecto de su reclamo, o si necesita alertar a la WCB sobre cualquier problema o situación que afecta su reclamo. Muchas de las acciones/situaciones requeridas con más frecuencia se enumeran como asuntos relacionados con pagos de indemnizaciones (puntos a al g) o asuntos médicos (puntos h al l); sin embargo usted no está limitado sólo a esos puntos. Marque todos aquéllos que correspondan y/o agregue información adicional o explicaciones en el espacio previsto para tal fin (m o n).

Complete la información de identificación en la parte superior del formulario ERFA-1W y envíelo, ADJUNTANDO TODA LA INFORMACIÓN QUE CORRESPONDA*. La WCB se comunicará con usted y todas las partes cuando trate su reclamo.

**A continuación de cada casilla de verificación verá la información necesaria en letras mayúsculas en negrita. Por ejemplo, si está informando a la WCB que su incapacidad ahora es permanente (recuadro i), la información requerida es el Formulario C-4.3, Informe del médico sobre Máxima mejoría médica/Incapacidad Permanente.*

DEBE ENVIAR UNA COPIA DE ESTE FORMULARIO A LA(S) COMPAÑÍA(S) DE SEGUROS, O DIRECTAMENTE AL EMPLEADOR O ADMINISTRADOR DE TERCEROS SI EL EMPLEADOR ESTÁ AUTO ASEGURADO.

En caso de albergar otras inquietudes, puede comunicarse con el **DEFENSOR(A) PARA LOS TRABAJADORES LESIONADOS al 1-800-580-6665**. Puede obtener información adicional sobre otros servicios que ofrece la WCB en su sitio web: WWW.WCB.NY.GOV. Si desea realizar un seguimiento en línea de su reclamo, puede registrarse para ingresar a eCase utilizando las instrucciones para registro que están disponibles en el sitio web de la WCB en el enlace eCase.

Ud. tiene derecho a tener un representante legal. Ningún abogado puede cobrarle directamente por la representación en un reclamo de indemnización laboral. Si se indica un monto a pagar en la sentencia sobre su reclamo, todos los honorarios legales deberán ser aprobados por la WCB, serán deducidos de dicho monto por la compañía de seguros y se pagarán directamente al abogado.

Medical Treatment - Medication/Durable Medical Equipment/Treatment/Test - This form is to be used when a medical request has been denied and you are requesting assistance from the Board regarding one of the reasons listed in box h. If prior authorization has not been requested yet and is required, your health care provider must submit a Prior Authorization Request (PAR). Information regarding submitting Prior Authorization Requests or unpaid medical bills can be found on the WCB website www.wcb.ny.gov.

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.

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. Sec. 552a).

The Workers' Compensation Board's (Board's) authority to request that injured worker's 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.