NYSIF

New York State Insurance Fund

199 CHURCH STREET. NEW YORK. NY 10007-1173

EMPLOYER'S REQUEST FOR REIMBURSEMENT

TO: WCB

ADDRESS:

CLAIMANT: _____ S.I.F. No.: _____

EMPLOYER: _____ W.C.B. No.: _____

_____ DATE OF ACCIDENT: _____

_____

SEE INSTRUCTIONS ON BACK

To the Workers' Compensation Board:

The undersigned employer hereby requests FULL REIMBURSEMENT, in accordance with the Workers' Compensation Law, for wages advanced during a period of absence due to disability.

The total amount advanced was _____ dollars and

_____ cents ($_____) for the period from _____

through _____.

DATE: _____

EMPLOYER'S REPRESENTATIVE:

Print Name _____

and Title _____

EMPLOYER'S SIGNATURE: _____

EMPLOYEE'S SIGNATURE : _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

NOTE TO EMPLOYER:

Under current interpretations of Section 25 of the Workers' Compensation Law, in cases involving temporary disability, an employer may not recover more than the compensation benefit rate for the period during which compensation or wages were advanced, nor may there be any reimbursement for the first week if the disability does not exceed two (2) weeks.

INSTRUCTIONS

1. This form is used principally as evidence of a claim for reimbursement by an employer for monies advanced to a claimant on account of compensation due under the provisions of the Workers' Compensation Law.

2. Attention is drawn specifically to Section 25 of the Workers' Compensation Law, from which the following is extracted:

> "...If the employer has made advance payments of compensation, or has made payments to an employee in like manner as wages during any period of disability, he shall be entitled to be reimbursed out of an unpaid installment or installments of compensation due, provided his claim for reimbursement is filed before award of compensation is made, or, if insured, by the insurance carrier at the direction of the board, unless he shall file a waiver of reimbursement with the chairman, in which event compensation will be paid to the claimant notwithstanding the advance payments..."

3. It is recommended that, while payments are being advanced, this form be completed monthly and mailed to the nearest office of The Workers' Compensation Board(See below). A copy of this form should be sent to the State Insurance Fund.

Mailing Addresses for The Workers' Compensation Board

ALBANY (12241) - 100 Broadway, Menands.

BINGHAMTON (13901) - State Office Building, 44 Hawley Street.

BUFFALO (14202) - Statler Towers, 107 Delaware Ave.

ROCHESTER (14614) - 130 Main Street West.

SYRACUSE (13203) - 935 James Street.

DOWNSTATE CENTRALIZED MAILING - (for New York City, Hempstead, Hauppauge & Peekskill district offices) - PO Box 5205, Binghamton, NY 13902-5205.