

Dear Injured Worker,

This packet's intention is to help you understand the claim process and introduce ourselves, NCAComp, Inc, as your Workers' Compensation carrier. If you do not understand any aspect of the claim process you can contact our office:

Toll Free Phone: (888)806-1109
Email: HelpDesk@NCAComp.com
Address: 14 Lafayette Sq. Suite 700
Buffalo, NY 14203
Website: NCAComp.com

If your claim is determined to be compensable and accepted, NCAComp will authorize and pay for related treatment and services you may need as a result of your injury. We will also work with you to return you to your pre-injury medical status and, in the event you lose time from work, to safely get you back to your job earning full wages as soon as possible.

Enclosed in this packet is the following:

- Information from the NYS Workers' Compensation Board about being injured at work
- C-3.0 – Employee Claim (**return to WCB at WCBClaimsFiling@WCB.NY.Gov**)
- Instructions for how to fill out the C-3.0 (retain for your records)
- Statement of Rights (retain for your records)
- C-3.3 – Limited Release of Health Information (**return to NCAComp at the above email address or address**)
- HIPAA Release (**return to NCAComp at the above email address or address**)
- Instructions for use of the HIPAA Release (retain for your records)
- Align Networks information (retain for your records and give to your provider for Physical Therapy, Occupational Therapy, Aquatic Therapy, Chiropractic or Acupuncture treatment due to the work related injury)
- DT-1 Notice – NCA works with OneCall Medical (OCM IPA, Inc) for any diagnostic tests and examinations (retain for your records and give to your provider for MRI, CT, EMG/NCS, Ultrasound, Xray)
- Prescription Drug Letter – First Fill Prescription (retain for your records and give to your pharmacy for prescriptions prescribed due to the work-related injury)
- DD-1 - Direct Deposit Authorization Form
- Receipt for this information packet (**return to NCAComp at the above email address or address**)

In order to expedite the processing of your claim, please sign and return the C-3.3, HIPAA Release and receipt for the information packet to our office at:

Email: HelpDesk@NCAComp.com
Address: 14 Lafayette Sq. Suite 700
Buffalo, NY 14203

Any person who knowingly and with intent to defraud an insurance company or other person files an application for insurance or statement of claim containing any material false information, or insurance statement of claim containing information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty no to exceed \$5,000 and the stand value of the claim for each violation.

By filling out the enclosed paperwork, you are not giving up any rights or payments due to you for your workers' compensation claim.

CO-PAYS and OFFICE VISIT: Please do NOT pay any money for your workers' compensation claim. You should not pay any copays for any medical visits or prescriptions. Your doctor should bill NCAComp, Inc directly.

PRESCRIPTIONS: NCAComp, Inc. works with a Pharmacy Benefits Provider (PBM). Please give the pharmacy of your choice the enclosed Prescription Drug Letter with our PBM information. If you do not use NCAComp's PBM, there is a chance that the services may be denied. If the pharmacy encounters any issues please tell them to contact NCAComp, Inc directly at (888)806-1109.

DIAGNOSTIC PROCEDURES (MRI, CT, EMG/NCS, Ultrasound, Xray): Please give your provider a copy of the DT-1 to ensure they're completed in a timely manner.

THERAPY (Physical Therapy, Occupational Therapy, Aquatic Therapy, Chiropractic or Acupuncture): Please give your provider a copy of Align Network's information to ensure treatment is authorized and completed in a timely manner.

Please feel free to contact our office at any time. If you would like to contact the NYS Workers' Compensation Board's Advocate for Injured Workers for additional information, please call (877)632-4996 and ask for the Advocate for Injured Workers' Office. Additional information can also be found on the Workers' Compensation Board's website: WCB.NY.Gov

We look forward to working with you throughout the process of your workers' compensation claim.

Sincerely,

NCAComp, Inc.

****Please complete the enclosed forms as soon as possible and return within ONE WEEK****
****You have the right to consult an attorney regarding any of the forms enclosed****

Any person who knowingly and with intent to defraud an insurance company or other person files an application for insurance or statement of claim containing any material false information, or insurance statement of claim containing information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed \$5,000 and the stand value of the claim for each violation.



Employee Claim

State of New York - Workers' Compensation Board

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.ny.gov.

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Employee)

1. Name: _____
First MI Last
2. Date of Birth: ____/____/____
3. Mailing address: _____
Number and Street/PO Box/Apartment No. City State Zip Code
4. Social Security Number: _____ - _____ - _____ 5. Phone Number: (____) _____ 6. Gender: M F X
7. Will you need a translator if you have to attend a Board hearing? Yes No If yes, for what language? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (____) _____
3. Your work address: _____
Number and Street City State Zip Code
4. Date you were hired: ____/____/____ 5. Your supervisor's name: _____
6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? Yes No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____
2. What types of activities did you normally perform at work? _____

3. Was your job? (check one) Full Time Part Time Seasonal Volunteer Other: _____
4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____
6. Did you receive lodging or tips in addition to your pay? Yes No If yes, describe: _____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: ____/____/____ 2. Time of injury: _____ AM PM
3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

4. Was this your usual work location? Yes No If no, why were you at this location? _____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____



YOUR NAME: _____
First MI Last

DATE OF INJURY/ILLNESS: ____/____/____

D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? Yes No If yes, what? _____
9. Was the injury the result of the use or operation of a licensed motor vehicle? Yes No
If yes, your vehicle employer's vehicle other vehicle License plate number (if known): _____
If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____
10. Have you given your employer (or supervisor) notice of injury/illness? Yes No
If yes, notice was given to: _____ orally in writing Date notice given: ____/____/____
11. Did anyone see your injury happen? Yes No Unknown If yes, list names: _____

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? Yes, on what date? ____/____/____ No, skip to Section F.
2. Have you returned to work? Yes No If yes, on what date? ____/____/____ regular duty limited duty
3. If you have returned to work, who are you working for now? Same employer New employer Self employed
4. What is your gross pay (before taxes) per pay period? _____ How often are you paid? _____

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? ____/____/____ None received (skip to question F-5)
2. Were you treated on site? Yes No
3. Where did you receive your first off site medical treatment for your injury/illness? none received Emergency Room
 Doctor's office Clinic/Hospital/Urgent Care Hospital Stay over 24 hours
Name and address where you were first treated: _____
_____ Phone Number: (____) _____
4. Are you still being treated for this injury/illness? Yes No
Give the name and address of the doctor(s) treating you for this injury/illness: _____
_____ Phone Number: (____) _____
5. Have you had another injury to the same body part, or a similar illness? Yes No
If yes, were you treated by a doctor? Yes No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**

6. Was the previous injury/illness work related? Yes No
If yes, were you working for the same employer that you work for now? Yes No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

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.

Employee's Signature: _____ Print Name: _____ Date: ____/____/____

On behalf of Employee: _____ Print Name: _____ Date: ____/____/____

An individual may sign on behalf of the employee only if they are legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): _____ Date: ____/____/____

Print Name: _____ Title: _____

ID No., if any: R _____ If Licensed Representative, License No.: _____ Expiration Date: ____/____/____



WCB Case No. (if you know it): _____

To Claimant: If you received treatment for a *previous* injury to the same body part or for an illness similar to the one described in your current Claim, fill out this form. This form allows the health care providers you list below to release health care information about your previous injury/illness to your employer's workers' compensation insurer. The federal HIPAA law (Health Insurance Portability and Accountability Act of 1996) says you have a right to get a copy of this form. If you do not understand this form, talk to your legal representative. If you do not have a legal representative, the Advocate for Injured Workers at the Workers' Compensation Board can help you. Call: 800-580-6665.

To Health Care Provider: A **copy** of this HIPAA-compliant release allows you to disclose health information. If you send records to the employer's workers' compensation insurer in response to this release, also mail copies to the Claimant's legal representative. (If no legal representative is listed below, send copies to the Claimant.) Health care providers who release records must follow New York state law and HIPAA.

This release is:

- **Voluntary.** Your health care provider(s) must give you the same care, payment terms, and benefits, whether you sign this form or not.
- **Limited.** It gives your health care provider(s) permission to release only those health records that are related to the previous illness/condition you describe below.
- **Temporary.** It ends when your current claim for compensation is established or disallowed and all appeals are exhausted.
- **Revocable.** You can cancel this release at any time. To cancel, send a letter to the health care provider(s) listed on this form. Also, send a copy of your letter to your employer's workers' compensation insurer and the Workers' Compensation Board. *Note: You may not cancel this release with respect to medical records already provided.*
- **For records only.** It gives your health care provider(s) listed on this form permission to send copies of your health care records to your employer's workers' compensation insurer.

This form does NOT allow your health care provider(s) to release the following types of information:

- **HIV-related information**
- **Psychotherapy notes**
- **Alcohol/Drug treatment**
- **Mental Health treatment** (unless you check below)
- **Verbal information** (your health care providers may not discuss your health care information with anyone)

Any medical records released will become part of your workers' compensation file and are confidential under the Workers' Compensation Law.

A. YOUR INFORMATION (Claimant)

1. Name: _____
2. Social Security Number: _____ - _____ - _____
3. Mailing Address: _____
4. Date of Birth: ____/____/____
5. Date of the current injury/illness: ____/____/____
6. Current injury/illness, including all body parts injured: _____
7. Your legal representative's name and address (if any): _____

Check here if you allow your health care provider(s) to release **mental health care** information.

B. YOUR HEALTH CARE PROVIDER(S) (List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers attach their contact information to this form.)

1. Provider: _____
2. Phone Number: (____) _____
3. Mailing Address: _____
4. Other provider (if any): _____
5. Phone Number: (____) _____
6. Mailing Address: _____

C. READ AND SIGN BELOW. I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above.

Claimant's signature (ink only – use blue ballpoint pen, if possible.) Date

If the claimant is unable to sign, the person signing on the claimant's behalf must fill out and sign below:

Your name Relationship to Claimant Signature (ink only – use blue ballpoint pen, if possible.) Date



WCB Case No. (if you know it) (Número de caso WCB [si lo sabe])

Al reclamante: Si usted recibió tratamiento por una lesión anterior en la misma parte del cuerpo o por una enfermedad similar a la que motiva ahora su reclamación, complete este formulario. Este formulario les permite a los proveedores de salud que usted señala a continuación divulgar a la compañía de seguros de compensación obrera de su empleador la información sobre su salud relacionada con su lesión/enfermedad anterior. La Ley federal HIPAA (Ley de portabilidad y responsabilidad del seguro de salud de 1996) establece que usted tiene derecho a recibir una copia de este formulario. Si no comprende este formulario, hable con su representante legal. Si no tiene un representante legal, el Representante de los obreros lesionados de la Junta de Compensación Obrera puede ayudarlo. Llame al 800-580-6665.

Al proveedor de salud: Una copia de esta divulgación, redactada según lo que establece la ley HIPAA, le permite divulgar información sobre la salud. Si envía los registros al asegurador de compensación obrera del empleador en respuesta a la presente divulgación, también debe enviar por correo copias al representante legal del reclamante. (Si a continuación no se especifica un representante legal, envíe las copias al reclamante). Los proveedores de salud que divulgan los registros deben cumplir con las leyes del estado de Nueva York y la HIPAA.

Esta divulgación es:
• Voluntaria. Su(s) proveedor(es) de salud deben otorgarle la misma atención, condiciones de pago y beneficios, independientemente de que usted firme este formulario o no.
• Limitada. Le otorga a su(s) proveedor(es) de salud permiso para divulgar únicamente los registros médicos que se relacionen con la enfermedad/afección anterior que usted describe a continuación.
• Temporal. Termina cuando se otorgue o desestime su actual reclamación de compensación y se hayan agotado todas las apelaciones.
• Revocable. Usted puede cancelar esta divulgación en cualquier momento. Para hacerlo, envíe una carta al (a los) proveedor(es) de salud que se indican en este formulario. Además, envíe una copia de su carta a la compañía de seguros de compensación obrera de su empleador y a la Junta de Compensación Obrera. Nota: No podrá cancelar esta divulgación en lo que se refiere a registros médicos que ya se hayan provisto.
• Solamente para registros. Le otorga a su(s) proveedor(es) de salud que se indica(n) en este formulario permiso para enviar copias de sus registros de salud a la compañía de seguros de compensación obrera de su empleador.

Este formulario NO autoriza a su(s) proveedor(es) de salud a divulgar los siguientes tipos de información:
• Información relacionada con el VIH
• Notas de terapia psicológica
• Tratamientos por abuso de alcohol o drogas
• Tratamiento de salud mental (a menos que usted lo indique a continuación)
• Información verbal (sus doctores no pueden hablar con nadie sobre su información de salud)

Los registros médicos divulgados se incorporarán a su expediente de compensación obrera y son confidenciales conforme a la Ley de compensación obrera.

CONTESTA LAS SIGUIENTES PREGUNTAS, EN INGLÉS SI ES POSIBLE, EN LOS ESPACIOS PROVISTOS Y FIRMA AL FRENTE DE LA FORMA.

A. YOUR INFORMATION (Claimant) INFORMACIÓN PERSONAL (Reclamante)

- 1. Name (Nombre) 2. Social Security Number (Número de seguro social)
3. Mailing Address (Dirección postal)
4. Date of Birth (Fecha de nacimiento) 5. Date of the current injury/illness (Fecha de la lesión/enfermedad actual)
6. Current injury/illness, including all body parts injured (Descripción de la lesión/enfermedad actual, incluyendo todas las partes del cuerpo lesionadas)
7. Your legal representative's name and address (if any) (Nombre y dirección de su representante legal [si corresponde])
Check here if you allow your health provider(s) to release mental health care information. (Marque aquí si autoriza a su(s) proveedor(es) de salud a divulgar información sobre tratamientos de salud mental.)

B. YOUR HEALTH CARE PROVIDERS (List all health care providers who treated you for a previous injury to the same body part or similar illness. If more than 2 providers, attach their contact information to this form.)

SU(S) PROVEEDOR(ES) DE SALUD (Enumere todos los proveedores de salud que le han tratado por lesiones previas a las mismas áreas del cuerpo ó por enfermedades semejantes. Si son más de 2 proveedores, adjunte su información de contacto a este formulario.)

- 1. Provider (Proveedor de salud) 2. Phone Number (Nº de teléfono)
3. Mailing Address (Dirección postal)
4. Other provider (if any) (Otro proveedor [si corresponde]) 5. Phone Number (Nº de teléfono)
6. Mailing Address (Dirección postal)

C. READ AND SIGN BELOW I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above. LEA Y FIRME A

CONTINUACIÓN. Por la presente solicito que los proveedores de salud aquí enumerados le provean al asegurador de compensación obrera de mi patrono copias de todos los records médicos relacionados a cualquier lesión/enfermedad aquí enumeradas.

If the claimant is unable to sign, the person signing on the claimant's behalf must fill out and sign below: (Si el reclamante no puede firmar, la persona que firme el formulario en su nombre y representación debe llenar y firmar a continuación)

Claimant's signature (Firma del reclamante) use solo tinta - preferiblemente azul Date (Fecha)

Your name (Su nombre) Relationship to Claimant (Relación con el reclamante) Signature(Firma) Date(Fecha)

Instructions for Completing Employee Claim (Form C-3)

Please complete this form and send it to the Workers' Compensation Board centralized mailing address listed at the end of these instructions. If you need additional help completing this form, contact the Workers' Compensation Board at **1-877-632-4996**. You may also fill this form out online at wcb.ny.gov. If you do not have or know your Workers' Compensation Board Case Number, please leave this field blank. It is not required to process your claim. Remember to enter your name and the date of your injury/illness on the top of page two.

Section A - Your Information (Employee):

In Section A, enter your name, address and other requested information.

Note on Item 7: Board hearings are conducted in English. If you need a translator, select **Yes** and indicate the language needed.

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. § 552a).

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

Section B - Your Employer(s):

In Section B, enter the name, address, phone number and other information of the employer you were working for at the time of the injury/illness.

Note: Your employer is the company or agency that issues your paycheck. If you are a contractor at a work site or office, the staffing agency or vendor who hired you is your employer, not the work site or office where you report to work.

Section C - Your Job on the Date of the Injury or Illness:

In Section C, enter your job title, work activities and pay information.

Section D - Your Injury or Illness:

In Section D, enter your injury or illness information.

Item 1: Enter the date you were injured or the first date you noticed you became ill.

If this is an illness or occupational disease, skip item 2. The date you were injured must be in month/day/year format. The year should be written as four digits, e.g., 2015.

Item 2: Enter the time when the injury occurred. Check whether it was AM or PM.

Item 3: Indicate the location where the injury/illness occurred, including the address of the building and the physical location in the building where the injury/illness happened.

Item 4: Check whether this was your normal work location. If it was not, explain why you were at this location.

Item 5: Describe in detail what you were doing at the time of the injury/illness (e.g., unloading boxes from a truck by hand). This explains the events leading up to the injury.

Item 6: Describe in detail how the injury/illness occurred (e.g., I was lifting a heavy box off a truck). This should include all people and events involved in the injury/illness.

Item 7: Indicate fully the nature and extent of your injury/illness, including all body parts injured. Be as specific as possible (e.g., I strained my back trying to lift a heavy box. It hurts to bend over or hold even lighter objects now).

Item 8: Indicate if some object was involved in the accident **other than** a licensed motor vehicle. Other objects may include a tool (e.g., hammer), a chemical (e.g., acid), machinery (e.g., forklift or drill press), etc.

Item 9: Indicate if a licensed motor vehicle was involved in the accident. If so, check if the motor vehicle involved was yours, your employer's, or a third party's. Include the license plate number (if known). If your vehicle was involved, fill out the name and address of your automobile liability insurance carrier.

Item 10: Check if you gave your employer or supervisor notice of your injury or illness. If so, indicate who you gave notice to as well as if it was orally or in writing. Include the date you gave notice.

Item 11: Check if anyone else saw the injury happen. If anyone did see it, include their name(s).

Section E - Return to Work:

Item 1: If you stopped working as a result of your work-related injury/illness, check Yes and indicate the date you stopped working. If you have not stopped working, check No and skip to the next section.

Item 2: If you have since returned to work, check Yes. Also indicate on what date you started working again, as well as if you have returned to your Normal Duties or if you are on Limited or Restricted Duty. (If you have not returned to your full pre-injury or illness work duties, then you are on Limited Duty.)

Item 3: If you have returned to work, indicate who you are working for now.

Item 4: Enter your gross pay (before tax pay) per pay period for the job you are working at now. Indicate how often you are receiving a paycheck (weekly, bi-weekly, etc.).

Section F - Medical Treatment for This Injury or Illness:

Item 1: If you did not receive medical treatment for this injury/illness, check None Received and skip to item 5. Otherwise, enter the date you first received treatment for this injury/illness and complete the rest of this section.

Item 2: Check if you were first treated on the job for this injury or illness.

Item 3: Check the location where you first received off site medical treatment for your injury or illness. Include the name and address of the facility as well as the phone number (including area code).

Item 4: If you are still receiving ongoing treatment for the same injury or illness, check Yes and indicate the name and address of the doctor(s) providing treatment as well as the phone number (including area code); otherwise, check No.

Item 5: If you already had an injury to the same body part or a similar illness, check Yes and indicate if you were treated by a doctor for this injury or illness. If you were treated by a doctor, indicate the name(s) and address(es) of the doctor(s) whom provided care and **complete and file Form C-3.3 together with this form.**

Item 6: If you had a previous injury or illness, check if your previous injury or illness was work-related. If Yes, check if the injury or illness happened while working for your current employer.

Sign Form C-3 in the place provided for Employee's Signature on page 2, print your name, and enter the date you signed the form. If a third-party is signing on behalf of the employee, that person should sign on the second signature line. If you have legal representation, your representative **must** complete and sign the attorney/representative's certification section on the bottom of page 2.

What Every Worker Should Do in Case of On-The-Job Injury or Occupational Disease:

1. Immediately tell your employer or supervisor when, where and how you were injured.
2. Secure medical care immediately.
3. Tell your doctor to file medical reports with the Board and with your employer or its insurance carrier.
4. Make out this claim for compensation and send it to the nearest Workers' Compensation Board Office. (See below.) Failure to file within two years after the date of injury may result in your claim being denied. If you need help in completing this form, telephone or visit the nearest Workers' Compensation Board Office listed below.
5. Go to all hearings when notified to appear.
6. Go back to work as soon as you are able; compensation is never as high as your wage.

Your Rights:

1. Generally, you are entitled to be treated by a doctor of your choice, provided they are authorized by the Board. If your employer is involved in a preferred provider organization (PPO) arrangement, you must obtain initial treatment from the preferred provider organization which has been designated to provide health care services for workers' compensation injuries.
2. DO NOT pay your doctor or hospital. Their bills will be paid by the insurance carrier if your case is not disputed. If your case is disputed, the doctor or hospital must wait for payment until the Board decides your case. In the event you fail to prosecute your case or the Board decides against you, you will have to pay the doctor or hospital.
3. You are also entitled to be reimbursed for drugs, crutches, or any apparatus properly prescribed by your doctor and for carfares or other necessary expenses going to and from your doctor's office or the hospital. (Get receipts for such expenses.)
4. You are entitled to compensation if your injury keeps you from work for more than seven days, compels you to work at lower wages, or results in permanent disability to any part of your body.
5. Compensation is payable directly and without waiting for an award, except when the claim is disputed.
6. Injured workers or dependents of deceased workers may represent themselves in matters before the Board or may retain an attorney or licensed representative to represent them. If an attorney or licensed representative is retained, their fee for legal services will be reviewed by the Board and if approved will be paid by the employer or insurance company out of any compensation benefits due. Injured workers or dependents of deceased workers should not directly pay anything to the attorney or licensed representative representing them in a compensation case.
7. If you need help returning to work, or with family or financial problems because of your injury, contact the Workers' Compensation Board office nearest you and ask for a rehabilitation counselor or social worker.

This form should be filed by sending directly to the address listed below:

**New York State Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205**

Customer Service Toll-Free Number: 877-632-4996

Instructions for Completing Employee Claim (Form C-3)

Please complete this form and send it to the Workers' Compensation Board centralized mailing address listed at the end of these instructions. If you need additional help completing this form, contact the Workers' Compensation Board at **1-877-632-4996**. You may also fill this form out online at **wcb.ny.gov**. If you do not have or know your Workers' Compensation Board Case Number, please leave this field blank. It is not required to process your claim. Remember to enter your name and the date of your injury/illness on the top of page two.

Section A - Your Information (Employee):

In Section A, enter your name, address and other requested information.

Note on Item 7: Board hearings are conducted in English. If you need a translator, select **Yes** and indicate the language needed.

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. § 552a).

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

Section B - Your Employer(s):

In Section B, enter the name, address, phone number and other information of the employer you were working for at the time of the injury/illness.

Note: Your employer is the company or agency that issues your paycheck. If you are a contractor at a work site or office, the staffing agency or vendor who hired you is your employer, not the work site or office where you report to work.

Section C - Your Job on the Date of the Injury or Illness:

In Section C, enter your job title, work activities and pay information.

Section D - Your Injury or Illness:

In Section D, enter your injury or illness information.

Item 1: Enter the date you were injured or the first date you noticed you became ill.

If this is an illness or occupational disease, skip item 2. The date you were injured must be in month/day/year format. The year should be written as four digits, e.g., 2015.

Item 2: Enter the time when the injury occurred. Check whether it was AM or PM.

Item 3: Indicate the location where the injury/illness occurred, including the address of the building and the physical location in the building where the injury/illness happened.

Item 4: Check whether this was your normal work location. If it was not, explain why you were at this location.

Item 5: Describe in detail what you were doing at the time of the injury/illness (e.g., unloading boxes from a truck by hand). This explains the events leading up to the injury.

Item 6: Describe in detail how the injury/illness occurred (e.g., I was lifting a heavy box off a truck). This should include all people and events involved in the injury/illness.

Item 7: Indicate fully the nature and extent of your injury/illness, including all body parts injured. Be as specific as possible (e.g., I strained my back trying to lift a heavy box. It hurts to bend over or hold even lighter objects now).

Item 8: Indicate if some object was involved in the accident **other than** a licensed motor vehicle. Other objects may include a tool (e.g., hammer), a chemical (e.g., acid), machinery (e.g., forklift or drill press), etc.

Item 9: Indicate if a licensed motor vehicle was involved in the accident. If so, check if the motor vehicle involved was yours, your employer's, or a third party's. Include the license plate number (if known). If your vehicle was involved, fill out the name and address of your automobile liability insurance carrier.

Item 10: Check if you gave your employer or supervisor notice of your injury or illness. If so, indicate who you gave notice to as well as if it was orally or in writing. Include the date you gave notice.

Item 11: Check if anyone else saw the injury happen. If anyone did see it, include their name(s).

Section E - Return to Work:

Item 1: If you stopped working as a result of your work-related injury/illness, check Yes and indicate the date you stopped working. If you have not stopped working, check No and skip to the next section.

Item 2: If you have since returned to work, check Yes. Also indicate on what date you started working again, as well as if you have returned to your Normal Duties or if you are on Limited or Restricted Duty. (If you have not returned to your full pre-injury or illness work duties, then you are on Limited Duty.)

Item 3: If you have returned to work, indicate who you are working for now.

Item 4: Enter your gross pay (before tax pay) per pay period for the job you are working at now. Indicate how often you are receiving a paycheck (weekly, bi-weekly, etc.).

Section F - Medical Treatment for This Injury or Illness:

Item 1: If you did not receive medical treatment for this injury/illness, check None Received and skip to item 5. Otherwise, enter the date you first received treatment for this injury/illness and complete the rest of this section.

Item 2: Check if you were first treated on the job for this injury or illness.

Item 3: Check the location where you first received off site medical treatment for your injury or illness. Include the name and address of the facility as well as the phone number (including area code).

Item 4: If you are still receiving ongoing treatment for the same injury or illness, check Yes and indicate the name and address of the doctor(s) providing treatment as well as the phone number (including area code); otherwise, check No.

Item 5: If you believe you already had an injury to the same body part or a similar illness, check Yes and indicate if you were treated by a doctor for this injury or illness. If you were treated by a doctor, indicate the name(s) and address(es) of the doctor(s) whom provided care and **complete and file Form C-3.3 together with this form.**

Item 6: If you had a previous injury or illness, check if your previous injury or illness was work-related. If Yes, check if the injury or illness happened while working for your current employer.

Sign Form C-3 in the place provided for Employee's Signature on page 2, print your name, and enter the date you signed the form. If a third-party is signing on behalf of the employee, that person should sign on the second signature line. If you have legal representation, your representative **must** complete and sign the attorney/representative's certification section on the bottom of page 2.

What Every Worker Should Do in Case of On-The-Job Injury or Occupational Disease:

1. Immediately tell your employer or supervisor when, where and how you were injured.
2. Secure medical care immediately.
3. Tell your doctor to file medical reports with the Board and with your employer or its insurance carrier.
4. Make out this claim for compensation and send it to the nearest Workers' Compensation Board Office. (See below.) Failure to file within two years after the date of injury may result in your claim being denied. If you need help in completing this form, telephone or visit the nearest Workers' Compensation Board Office listed below.
5. Go to all hearings when notified to appear.
6. Go back to work as soon as you are able; compensation is never as high as your wage.

Your Rights:

1. Generally, you are entitled to be treated by a doctor of your choice, provided he/she is authorized by the Board. If your employer is involved in a preferred provider organization (PPO) arrangement, you must obtain initial treatment from the preferred provider organization which has been designated to provide health care services for workers' compensation injuries.
2. DO NOT pay your doctor or hospital. Their bills will be paid by the insurance carrier if your case is not disputed. If your case is disputed, the doctor or hospital must wait for payment until the Board decides your case. In the event you fail to prosecute your case or the Board decides against you, you will have to pay the doctor or hospital.
3. You are also entitled to be reimbursed for drugs, crutches, or any apparatus properly prescribed by your doctor and for carfares or other necessary expenses going to and from your doctor's office or the hospital. (Get receipts for such expenses.)
4. You are entitled to compensation if your injury keeps you from work for more than seven days, compels you to work at lower wages, or results in permanent disability to any part of your body.
5. Compensation is payable directly and without waiting for an award, except when the claim is disputed.
6. Injured workers or dependents of deceased workers may represent themselves in matters before the Board or may retain an attorney or licensed representative to represent them. If an attorney or licensed representative is retained, his/her fee for legal services will be reviewed by the Board and if approved will be paid by the employer or insurance company out of any compensation benefits due. Injured workers or dependents of deceased workers should not directly pay anything to the attorney or licensed representative representing them in a compensation case.
7. If you need help returning to work, or with family or financial problems because of your injury, contact the Workers' Compensation Board office nearest you and ask for a rehabilitation counselor or social worker.

This form should be filed by sending directly to the address listed below:

**New York State Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205**

Customer Service Toll-Free Number: 877-632-4996

Occupational injury/illness STATEMENT OF RIGHTS



Workers'
Compensation
Board

To all workers who are injured while working or who suffer from an occupational disease: You may be entitled to workers' compensation benefits

1. You may be entitled to lost wage benefits if your work-related injury/illness keeps you from work for more than seven days, causes you to earn lower wages, or results in a permanent disability. In volunteer firefighters' and volunteer ambulance workers' cases, compensation for lost time or loss of earning capacity may be payable from date of injury/illness.
2. You are entitled to medical treatment related to your injury/illness and should get it immediately. You can see any health care provider in an emergency. After that, you must see a NYS Workers' Compensation Board (Board) authorized provider or go to an occupational health clinic. You can search for a provider at wcb.ny.gov. Do not pay the health care provider directly; they will bill your employer's workers' compensation insurer. If that insurer has a pharmacy or diagnostic network, you must receive services within these networks. The insurer must tell you about its required provider networks and how to use them.
3. Your employer is liable for repairing or replacing any prosthesis (e.g., artificial members, false teeth, eyeglasses) that has been lost or damaged in the course of employment. You are also entitled to reimbursement for medication, crutches, or any equipment properly prescribed by your provider, as well as transportation and other necessary expenses for travel to and from your health care provider's office or hospital. (You should get receipts for all such expenses.)
4. Your employer is not permitted to ask you to waive your right to compensation or deduct money from your wages to pay for workers' compensation insurance premiums. Further, you cannot be fired or discriminated against because you filed a claim for benefits.
5. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire an attorney or licensed representative, you should not pay them directly. Any fee will be set by the Board and will be deducted from your award.
6. If your claim is disputed on the grounds that your injury/illness is not work-related or did not arise in the line of volunteer firefighter or ambulance worker duties, then you may be required to cover the costs of your medical treatment. You may qualify for disability benefits for non-work injuries. For information on disability benefits, contact the Board at [\(877\) 632-4996](tel:877-632-4996).

Note: A quick return to work and an active lifestyle may help you get better faster. For help returning to work, or with family or financial problems due to your injury/illness, call the Board at [\(877\) 632-4996](tel:877-632-4996) and ask for vocational rehabilitation or social work assistance.

To file a claim:

1. Tell your employer, in writing, that you were injured or made ill due to your job, within 30 days of the accident or onset of illness.
2. Report your injury/illness to the Board as soon as possible. To do so, obtain and file an *Employee Claim (Form C-3)*. Note: Volunteer firefighters file the *Volunteer Firefighter's Claim for Benefits (Form VF-3)*, volunteer ambulance workers file the *Volunteer Ambulance Worker's Claim for Benefits (Form VAW-3)*.
IMPORTANT: If you do not notify the Board of your injury or illness within two years, you risk losing the right to benefits.
3. Tell your health care provider to send copies of medical reports concerning your claim to the Board and to your employer's insurance company at the addresses on the bottom of this form.

FOR HELP OBTAINING A CLAIM FORM OR FILLING IT OUT, OR OTHER QUESTIONS ABOUT A WORK-RELATED INJURY OR ILLNESS, PLEASE CALL [\(877\) 632-4996](tel:877-632-4996). A BOARD REPRESENTATIVE WILL HELP YOU.

This information is a simplified presentation of your rights under the Workers' Compensation Law. It is provided, as required by Section 110 of the Workers' Compensation Law, by your employer's insurance carrier:

NCAComp, Inc.
14 Lafayette Square, Ste 700
Buffalo, NY 14203

PRESCRIBED BY THE CHAIR,
WORKERS' COMPENSATION BOARD
NYS Workers' Compensation Board,
Centralized Mailing, PO Box 5205,
Binghamton, NY 13902-5205

WCB.NY.GOV



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

Medical Record from (insert date) _____ to (insert date) _____

Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

Other: _____ Include: *(Indicate by Initialing)*

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) By initialing here _____ I authorize _____
Initials Name of individual health care provider
to discuss my health information with my attorney, or a governmental agency, listed here:

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: <input type="checkbox"/> At request of individual <input type="checkbox"/> Other:	11. Date or event on which this authorization will expire:
--	--

12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
--	---

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Signature of patient or representative authorized by law. Date: _____

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Instructions for the Use
of the HIPAA-compliant Authorization Form to
Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act (“HIPAA”) and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as “at the conclusion of my court case” or provide a specific date amount of time, such as “3 years from this date”.

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.



Notice That Claimant Must Arrange for Diagnostic Tests & Examinations through a Network Provider

DT-1

State of New York - Workers' Compensation Board

Claimants are required to obtain Diagnostic Tests and Examinations through the Carrier's Diagnostic Testing Network(s) identified below. This Notice is supplied to the Claimant and Treating Medical Provider pursuant to Workers' Compensation Law §13-a(7) and 12 NYCRR 325-7. Failure to provide the required notice relieves the Claimant of his/her obligation to use the diagnostic testing network(s).

NCAComp, Inc.

Date of Notice: _____

Check the applicable box below:

Notice to the Claimant

Claimant: _____ WCB Case Number: _____
First Name Middle Initial Last Name (If Available)

Mailing Address: _____

Carrier Case Number: _____

Notice to the Treating Medical Provider

Name of Treating Medical Provider: _____ Authorization No.: _____

Mailing Address: _____

Identify the Diagnostic Examination or Test that the Claimant must schedule using the Diagnostic Testing Network (check all applicable boxes):

- All MRI CT EMG/NCS Diagnostic Ultrasound X-Ray
- Other: _____

To schedule a diagnostic examination or test, contact the Diagnostic Testing Network listed below:

Diagnostic Testing Network

Identify the diagnostic testing network name, address, toll-free telephone number and any web address or e-mail contact information below.

Diagnostic Testing Network: OCM IPA, Inc.

Mailing Address: 20 Waterview Boulevard, Parsippany, NJ 07054

Phone Number: (800) 872-2875 Fax Number: (866) 632-2161

Web Address: www.onecallmedical.com E-mail Address: referrals@onecallmedical.com

STATEMENT OF RIGHTS AND OBLIGATIONS - DIAGNOSTIC TESTING NETWORKS (WCL §13-a(7) and 12 NYCRR §325-7)

1. The claimant will receive the name, address and phone number of at least five [5] providers. The providers must be located within a reasonable distance from the claimant's home or work. The network must provide the claimant with all providers if there are fewer than five [5] within a reasonable distance.
2. The test must be scheduled and performed within five [5] business days of the request. If the network asks the carrier to approve the test, it must still be performed within five [5] business days of the request from claimant's doctor.
3. The claimant may select *any* network provider to perform the test.
4. The claimant may discuss with his or her doctor which provider to choose.
5. The claimant should share this notice with all of his or her doctors.
6. The claimant does not have to use a network provider under these circumstances:
 - a. The provider can't schedule the test within five [5] business days.
 - b. The carrier has challenged (controverted) or will controvert the claim.
 - c. In a medical emergency.
 - d. For x-rays taken during an office visit and used for diagnosis and treatment of: fractures, possible fractures, joint dislocations, tumors, infections, loosening of surgical implants, dislocation of prosthetic joints, spinal instability, or follow-up to surgery.
7. If the carrier doesn't provide the required notice, the carrier must pay for tests outside of the network.
8. On written request, the network will provide the actual test film, data or digital images to the claimant's doctor. These items will be sent to the claimant's doctor with the report or within three [3] business days of receipt of the written request. A doctor may order a second test from the network for the purpose of obtaining an accurate diagnosis as set forth in the Medical Treatment Guidelines if the quality of the test is inadequate.
9. The claimant is entitled to reimbursement for reasonable travel costs to and from the provider.

If DIAGNOSTIC TESTING is required, give this form to your doctor.

More information on diagnostic testing networks is available in Subject Number 046-480, located on the Board's website under Board Bulletins and Subject Numbers.

MAKING IT EASY TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured person:



If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. In most cases, the pharmacy will fill the prescription at no cost to you.



If your workers' compensation claim is accepted, you will receive a permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.



Employer:

Immediately upon receiving notice of injury, fill in the information below and give this form to the employee.





Finding a network pharmacy

Most pharmacies and all major chains are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.



Questions? Need Help?

1-866-599-5426

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

CARRIER/TPA	EMPLOYER
INJURED PERSON NAME	
Please provide directly to Pharmacist	
SOCIAL SECURITY NUMBER	DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.
Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk

1-800-964-2531

	NDC	Envoy
RxBIN	004261	or 002538
RxPCN	CAL	or Envoy Acct. #
GROUP	_____	

NOTE: This First Fill card is only valid for your workers' compensation injury or illness.

HACEMOS MÁS SENCILLO QUE SE LE ABASTEZCA LAS RECETAS DE SU PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Persona lesionada:



Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. En la mayoría de los casos, la farmacia abastecerá la receta sin costo para usted.



Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.



Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información que aparece a continuación y entregue este formulario al empleado.



Cómo encontrar una farmacia de la red

La mayoría de farmacias y todas las grandes cadenas de farmacias forman parte de la red. Para ubicar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.



¿Tiene alguna pregunta? ¿Necesita ayuda?

1-866-599-5426




WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

PORTADORA	EMPLEADOR
NOMBRE DEL PERSONA LESIONADA	
Please provide directly to Pharmacist	
NUMERO DE SEGURO SOCIAL	FECHA DE LA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk

1-800-964-2531

	<u>NDC</u>	<u>Envoy</u>
RxBIN	004261	or 002538
RxPCN	CAL	or Envoy Acct. #
GROUP	_____	

NOTA: Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

DIRECT DEPOSIT AND DEBIT CARD AUTHORIZATION FORM

Directions: To begin, change or cancel the transmittal of workers' compensation benefit checks and/or proceeds from a settlement agreement pursuant to WCL § 32 (hereinafter settlement proceeds) directly to a Financial Institution or to a debit card. Read, complete and send this form to the insurance carrier/self-insured employer responsible for your workers' compensation claim. **Do not send to the Workers' Compensation Board.**

CLAIMANT'S RIGHTS

- This form is optional. You have the right to receive your workers' compensation benefits or settlement proceeds by paper check in the mail.
- You have the right to access all settlement proceeds at any time. If a debit card limits your daily withdrawals, you may request that settlement proceeds be paid by a paper check delivered in the mail.
- There is no limit on the amount or frequency of direct deposit or debit card withdrawals unless by express written agreement with the insurance carrier/self-insured employer responsible for your workers' compensation claim, and with the approval of the Workers' Compensation Board.
- You have the right to cancel the direct deposit or debit card at any time by checking the appropriate box on this form and forwarding the completed form to the insurance carrier or self-insured employer responsible for the workers' compensation claim.
- The insurance carrier/self-insured employer must present a debit card that is associated with a fully insured bank and the account must be in your name.
- All terms and conditions of the debit card must be disclosed to you at the time of enrollment.

AUTHORIZATIONS & UNDERSTANDINGS

- I authorize the insurance carrier and/or self-insured employer to directly deposit my workers' compensation benefits or settlement proceeds into the specified bank account or onto a debit card.
- I authorize the insurance carrier and/or self-insured employer to debit the account in order to recover any credits deposited in error. The insurance carrier and/or self-insured employer may recover credits deposited in error by any lawful means.
- I understand this consent does not authorize the insurance carrier and/or self-insured employer to recover alleged overpayments of established and awarded benefits.
- I understand that any change in my employment status may affect my right to receive benefits.
- I understand that any false statement or failure to disclose a material fact in order to obtain or increase my benefits may result in criminal prosecution, disqualification from benefits, and repayment of any funds deposited to my account.
- I understand that the failure to notify the insurance carrier and/or self-insured employer of any change in financial institution or account may delay receipt of my benefits or settlement proceeds.
- I understand that in order to change or cancel the direct deposit or debit card for my workers' compensation benefits or settlement proceeds, I need to submit this form to the insurance carrier and/or self-insured employer.



DIRECT DEPOSIT AUTHORIZATION FORM

NEW ENROLLMENT CHANGE CANCEL

SECTION 1 (TO BE COMPLETED BY CLAIMANT)

Claimant's Name (last, first):	WCB Claim Number:
Phone Number (including area code):	E-mail Address:
Address:	Account Type: <input type="checkbox"/> Direct Deposit <input type="checkbox"/> Debit Card
	For Direct Deposit: <input type="checkbox"/> Checking (attach voided check) <input type="checkbox"/> Savings Amount or Percentage to be deposited: _____

DEPOSITOR/CLAIMANT/JOINT ACCOUNT HOLDER CERTIFICATION

I certify that I am entitled to receive the underlying compensation payments or settlement proceeds and circumstances entitling me to benefits or settlement proceeds have not changed. In signing this form, I authorize my benefits or settlement proceeds to be deposited into my account in the financial institution named, or sent to a debit card in my name.

Depositor/Claimant Certification Signature	Date
Joint Account Holder Certification Signature	Date

SECTION 2 (TO BE COMPLETED BY FINANCIAL INSTITUTION)

Must be completed by your Financial Institution only if directing funds into a savings account or if, for deposit into a checking account, a voided personal check is **not** attached. The claimant's name **MUST** appear on the account.

Name of Financial Institution:	Account Type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings
Depositor's Account Number (EFT Format):	Routing Number:

As a representative of the above named Financial Institution, I certify that this institution is ACH capable and agrees to receive and deposit the compensation payment to the account shown above. Compensation payments credited to the above account will be available to the depositor on payday.

Print or Type Representative's Name	Phone Number (including area code):
Signature of Representative	Date

Receipt for Employee Information Packet:

I have this day, _____, received a copy of the Employee Information which includes the following:

C-3: Employee Claim for Compensation (return to local Workers' Compensation Board)

Instructions for how to fill out the C-3 form, including a toll free number for assistance (retain for your records)

Statement of Rights (retain for your records)

C-3.3: Limited Release of Health Information (return to NCAComp, Inc. at the enclosed address)

HIPAA Release (return to NCAComp, Inc. at the enclosed address)

Prescription Drug letter (retain for you records & present to your pharmacist)

DT-1: Notice That Claimant Must Arrange for Diagnostic Tests & Examinations Through a Network Provider

DD-1: Direct Deposit Authorization Form (return to NCAComp, Inc.)

NAME: _____

DATE: _____

EMPLOYEE SIGNATURE: _____