

State of New York  
WORKERS' COMPENSATION BOARD

## CLAIMANT'S REQUEST FOR FURTHER ACTION

**INSTRUCTIONS:** To request Board action on a case, complete this form and submit it to your local WCB district office. See mailing addresses on the reverse side. ATTACH ALL APPLICABLE EVIDENCE FOR CONSIDERATION BY THE BOARD. You must also send a copy of this form to your employer's workers' compensation insurance carrier, or directly to your employer or its third party administrator, if it is self-insured. This form is NOT to be used to APPEAL a decision.

ALL COMMUNICATIONS SHOULD REFER TO THESE NUMBERS				3. SOCIAL SECURITY NO.				4. DATE OF INJURY				5. WCB DISTRICT OFFICE			
1. WCB CASE NO.				2. CARRIER CASE NO. (if known)				m m d d y y				m m d d y y			
NAME								ADDRESS TO WHICH NOTICES SHOULD BE SENT							
6. CLAIMANT												APT. NO.			
7. EMPLOYER															
8. CARRIER															
9. ATTORNEY OR LICENSED REP.												ATTY/REP I.D. NO.			
												R			
CHECK HERE <input type="checkbox"/> IF CLAIMANT'S ADDRESS SHOWN ABOVE IS NEW.															

### REASON FOR THIS REQUEST

(Check all that apply - use item p. for explanation or additional information - see reverse side for further explanation)

<p>10. CLAIMANT</p> <p><input type="checkbox"/> a. requests referral for Administrative Determination/Conciliation/Hearing, as appropriate, because (please check the appropriate box[es] below):</p> <p><input type="checkbox"/> b. he/she has had a change of medical condition. <small>IF THIS BOX IS CHECKED, ATTACH MEDICAL REPORT. IF REPORT WAS PREVIOUSLY SUBMITTED, IDENTIFY IT IN ITEM o. BELOW BY DATE, DOCTOR'S NAME AND FORM ID, IF ANY.</small></p> <p><input type="checkbox"/> c. he/she is not working and not receiving payments.</p> <p><input type="checkbox"/> d. his/her payments have been suspended/reduced.</p> <p><input type="checkbox"/> e. he/she has returned to work at full wages.</p> <p><input type="checkbox"/> f. he/she is working at reduced earnings.</p> <p><input type="checkbox"/> g. he/she has not been paid as directed in a notice of decision.</p>	<p><input type="checkbox"/> h. a request for medical treatment was denied or not addressed.</p> <p><input type="checkbox"/> i. a request for medical and transportation reimbursement was denied.</p> <p><input type="checkbox"/> j. he/she now has medical evidence of permanency.</p> <p><input type="checkbox"/> k. new or requested evidence is now available.</p> <p><input type="checkbox"/> l. claimant's representative's fee has not been paid.</p> <p><input type="checkbox"/> m. he/she has discontinued or settled a lawsuit pertaining to this accident/injury.</p> <p><input type="checkbox"/> n. claimant has a change of address (please provide new address in 6., above).</p> <p><input type="checkbox"/> o. he/she has been released from incarceration and is applying for benefits (attach proof of release).</p> <p><input type="checkbox"/> p. other (explain fully in the space provided below.)</p>
<p>ATTACH ALL APPLICABLE EVIDENCE FOR CONSIDERATION BY THE BOARD. IF MEDICAL EVIDENCE WAS PREVIOUSLY SUBMITTED, IDENTIFY IT BY DATE, DOCTOR'S NAME AND FORM ID, IF ANY, IN THE SPACE PROVIDED ABOVE.</p>	

11. Have the above issues been resolved by agreement?  Yes  No If Yes, please attach documentation.  
If No, have you attempted to resolve the issue(s) checked above with the other parties?  Yes  No

I hereby certify that a copy of this form with attachment(s) was submitted to the other party(ies) in this case in accordance with the instructions above.

PREPARED BY (Please Print Name)	DATE PREPARED m m d d y y	AREA CODE TELEPHONE NUMBER

This form is submitted by  claimant  claimant's representative

## To the Claimant/Claimant's Representative - General Information On Using This Form

You or your attorney or licensed representative may file this form with the Workers' Compensation Board when you want the Board to take a specific action in your case, or if you need to alert the Board to any problem or situation that is affecting your case. Many of the most frequently requested actions/situations are contained in item 10 but you are not limited to those listed. Check all that apply and/or add additional information or explanation in the space provided (10p.). IF POSSIBLE, CONTACT THE INSURANCE CARRIER AND ATTEMPT TO RESOLVE THE ISSUE BEFORE SUBMITTING THIS FORM TO THE BOARD.

Complete the identifying information at the top of the form and send the form, WITH ALL APPLICABLE EVIDENCE ATTACHED, to your local Workers' Compensation Board district office (see addresses below). The Board will contact you when it takes action on your case.

YOU MUST SEND A COPY OF THIS FORM TO YOUR EMPLOYER'S WORKERS' COMPENSATION INSURANCE CARRIER OR DIRECTLY TO THE EMPLOYER OR ITS THIRD PARTY ADMINISTRATOR, IF IT IS SELF-INSURED.

Should you have any questions about this form or the documentation needed, contact your attorney, licensed representative, or the nearest office of the Workers' Compensation Board. When corresponding with the Board, please use your WCB case number.

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 Web site: **WWW.WCB.STATE.NY.US**.

## Información general para Reclamantes/Representates de Reclamantes en como usar esta forma.

Usted, su abogado ó su Representante autorizado pueden radicar esta forma en la Junta de Compensación Obrera cuando usted quiera que la Junta tome una acción específica en su caso ó si usted quiere notificar a la Junta de algun problema o situación que afecte su caso. La mayoría de las situaciones o requerimientos más frecuentes estan contenidos en el apartado 10 pero usted no está limitado a los allí enumerados. Marque todos los que apliquen y añada información adicional o explicaciones en el espacio provisto[10p.]. SI ES POSIBLE, CONTACTE A LA COMPAÑIA DE SEGUROS Y TRATE DE RESOLVER EL ASUNTO ANTES DE RADICAR ESTA FORMA EN LA JUNTA.

Complete la información de identificación en la parte superior de la forma y envíela, ADJUNTANDO TODA LA EVIDENCIA QUE APLIQUE, a la oficina local de distrito de la Junta de Compensación Obrera {vea direcciones abajo}. La Junta le avisará cuando tome acción en su caso.

USTED TIENE QUE ENVIAR UNA COPIA DE ESTA FORMA A LA COMPAÑIA DE SEGUROS DE SU PATRONO Ó DIRECTAMENTE A SU PATRONO, SI EL ES SU PROPIO ASEGURADOR.

Si usted tiene alguna pregunta sobre esta forma o la documentación requerida, comuníquese con su abogado, representante licenciado, ó la oficina más cercana de la Junta de Compensación Obrera. Cuando se comunique con la Junta siempre use su WCB número de caso.

Si usted tiene alguna duda puede comunicarse con el **DEFENSOR DE EMPLEADOS LESIONADOS** al **1-800- 580-6665**.

Información adicional sobre otros servicios de la Junta pueden obtenerse en el Web: **WWW.WCB.STATE.NY.US**.

## ADDITIONAL INFORMATION

Upon the submission of this form with the applicable documentary evidence, the Board will take immediate action to advance your claim toward resolution. Some of these actions include, but are not limited to the following:

- **Proposing an Administrative Determination** An Administrative Determination is a decision concerning your claim rendered by the Board. Generally, an administrative determination provides a fair, timely, and efficient mechanism for processing uncontroverted claims involving minor injuries, uncontested issues within a claim, and certain penalties. Prior to rendering an administrative determination decision, all the evidence in your file is examined and the decision is approved by a WCL Judge. Once the decision has been sent to the parties, any party may object within 30 days. If there is no objection, the decision becomes final. The appearance of the parties for a hearing at the Board is NOT necessary because acceptance of the Administrative Decision indicates that all the parties are satisfied with the resolution of the issue(s).

- **Placing your claim into Conciliation for resolution** Conciliation is a faster and less formal way of resolving your claim. If your claim is not controverted, and the lost time or reduced earnings is expected to be less than 52 weeks, the Board's Senior Attorneys/Conciliators work with the parties and their representatives, if any, to secure all necessary documentation and resolve all outstanding issues in your claim. Once the file has been thoroughly reviewed, the Senior Attorney/Conciliator will propose a decision and send it to the parties or will schedule a meeting at the Board with the parties if it is necessary. Within 30 days after the filing of a proposed decision, any party may submit to the Board its written comments. If there are no objections to the proposed decision, it becomes final in 30 days. Use of this form replaces Form CB-8 (Request for Conciliation).

- **Notifying the parties of a Hearing before a WCL Judge** If your claim involves issues which are complex and may require testimony, a formal hearing before a Workers' Compensation Law Judge may be necessary for resolution. A formal hearing requires a personal appearance by all parties in the case at the Board hearing location most convenient to the claimant. The hearing will be recorded and an official record kept by the Board. While the WCL Judge will generally render a decision orally at the hearing, a written decision will be sent to all parties following the hearing. Parties may appeal the written decision to the Board's Administrative Review Division within 30 days of its filing.

- **Referring your claim to the Administrative Review Division** If your claim has been previously resolved by a lump sum settlement or by a finding as to compensability, permanency, or entitlement to death benefits, the Administrative Review Division will review your file to determine whether your claim should be reopened and further action taken.

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") authority to request personal information from claimants is derived from Sections 20 and 142 of the Workers' Compensation Law. This information is collected to assist the Board in processing claims in an efficient manner and to help it maintain accurate claim records.

The Board is strongly committed to protecting the confidentiality of all personal information that it collects. Such information will be disclosed within the agency only to Board personnel and agents in furtherance of their official duties. Personal information will be disclosed outside the agency only in accordance with applicable state and federal law.

The Board's Director of Operations, located at 100 Broadway, Menands, New York 12241 (518-474-6674), is primarily responsible for the maintenance of agency records containing personal claimant information.

Failure to provide the information requested on this form will not result in the denial of your claim, but may delay the processing of your claim. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your claim.

### DOWNSTATE CENTRALIZED MAILING

(for New York City, Hempstead, Hauppauge & Peekskill Districts)

PO Box 5205 Binghamton, NY 13902-5205

100 Broadway

Menands

ALBANY 12241

(866) 750-5157

State Office Building

44 Hawley Street

BINGHAMTON 13901

(866) 802-3604

Statler Towers

107 Delaware Ave.

BUFFALO 14202

(866) 211-0645

130 Main Street W.

ROCHESTER 14614

(866) 211-0644

935 James St.

SYRACUSE 13203

(866) 802-3730

NYC (800)877-1373 / Hemp. (866)805-3630 / Haup. (866)681-5354 / Peek. (866)746-0552

**RFA-1 (3-08 Reverse)**

[www.wcb.state.ny.us](http://www.wcb.state.ny.us)