NYS Workers' Compensation Board, Centralized Mailing, PO Box 5205, Binghamton, NY 13902-5205

Statewide Fax Line: 877-533-0337
Customer Service: 877-632-4996

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

APPLICATION FOR REOPENING OF CLAIM, MORE THAN SEVEN YEARS AFTER ACCIDENT

NOTICE: This form must be filed immediately with the Chair, Workers' Compensation Board, together with attending doctor's report (Form C-27) if required, at the district office where the case was closed. Information on reverse side must be completed.

ANSWER ALL QUESTIONS FULLY - PRINT OR TYPE CLEARLY

W.C.B. Case No. _____ Date of Accident _____ Claimant's Social Security No. _____

1. Name of injured _____ Sex _____ Date of Birth _____

   Present address _____ Apt. No. _____

2. Employer (at time of accident) _____

   Address _____

3. When did you last work for this employer? _____

4. Name of present attending doctor _____

   Address _____

5. If injured employee is deceased, give date of death _____

6. Nature of injury _____

7. State specific reasons why you desire reopening of your case _____

   _____

   _____

8. RECORD OF MEDICAL TREATMENT SINCE THE ACCIDENT (List all doctors and hospitals):

Doctor or Hospital	Address	Period
_____	_____	From _____ To _____
_____	_____	From _____ To _____
	_____	From _____ To _____

9. Were you originally provided with any apparatus or appliances for your injury or furnished with treatment at the time of the accident? ..... ☐Yes ☐No

   (a) If "Yes," who provided and paid for it? _____

   (b) Has such apparatus been replaced or repaired? ..... ☐Yes ☐No

   (c) If "Yes," by whom and on what date? _____

   _____

10. Has any medical or surgical treatment or hospital care been furnished to you by employer or insurance carrier within the last 8 years? ..... ☐Yes ☐No

11. Has apparatu sor artificial appliance been furnished or repaired by employer or insurance carrier within the last 8 years? ..... ☐Yes ☐No

12. Did you sue anyone other than filing for compensation as a result of your accident?..... ☐Yes ☐No

    If "Yes," provide the following:

    Name and address of attorney _____

    Date settled _____ Amount of Settlement: $ _____

    Submit copy of settlement papers, if available.

(Complete the information on the reverse side)

13. Has any compensation been paid to you within the past 8 years?..... ☐Yes ☐No
If "Yes," give the following information:

(a) When was last payment made? _____

(b) By whom? _____

(c) Were you given lighter duties?..... ☐Yes ☐No

(d) If Yes to (c), were benefits received for reduced earnings?..... ☐Yes ☐No

14. Have you sustained any other injury since the closing of your case?..... ☐Yes ☐No
If "Yes," state the following:

(a) Nature of such injury _____

(b) Date of accident _____

(c) Name of the employer _____

(d) W .C.B. Case Number _____

(e) Last date of hearing _____

15. Are you currently working?..... ☐Yes ☐No

If If you **<u>are not</u>** currently working, are you retired?..... ☐Yes ☐No
you **are** currently working, give the following information:

(a) Name of latest employer _____

Address _____

Employer's NYS U.I.Registration No. (if known) _____

(b) When did present period of disability begin? _____
(Date)

(c) Give first and last date you worked on the job immediately preceding present disability:

First day worked _____ Last day worked _____

(d) Are you receiving disability benefits for your present period of disability?..... ☐Yes ☐No

If "Yes," from whom? _____

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.

Claimant's
Signature _____ Telephone No. _____ Dated _____

Mail Address _____

IMPORTANT

Authorization must be received from the Chair, Workers' Compensation Board, before securing medical treatment or supplies. Otherwise, claimant will be responsible for said medical treatment or supplies.

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.

IF YOU HAVE QUESTIONS OR NEED ADVICE ABOUT YOUR CLAIM, YOU MAY CALL OR VISIT THE NEAREST OFFICE OF THE WORKERS' COMPENSATION BOARD.
SI USTED TIENE ALGUNAS PREGUNTAS O NECESITA CONSEJO SOBRE SU RECLAMACION, USTED PUEDE LLAMAR O VISITAR LA OFICINA DE LA JUNTA DE COMPENSACION MAS CERCANA A USTED.