NEW YORK STATE **Workers' Compensation Board**

VOLUNTEER FIREFIGHTER'S CLAIM FOR BENEFITS

as of 11/2023

YOU MUST CALL (855) 456-8910 FOR A CASE NUMBER

Does this claim involve disease or malfunction of the heart or of one or more coronary arteries? (Check one) ☐ Yes ☐ No

W.C.B. CASE NO. (if known)	CARRIER CASE NO. (if known)	CARRIER CODE NO.	DATE OF INJURY	SOCIAL SECURITY NO.

	First Name	Middle Initial	Last Name	Address (Give Number and Street, City, State, Zip Code)	Apt. No.
1. VOLUNTEER FIREFIGHTER					
2. FIRECOMPANY					
3. POLITICAL SUBDIVISION LIABLE FOR BENEFITS					

INFORMATION, REGULAR WORK

4. (a) Marital Status _____ (b) Gender ☐ M ☐ F ☐ X (c) Date of Birth _____ (d) Tel. No. _____
5. Describe in detail your duties in regular employment _____
6. Your work week at time of injury was (check one) ☐ 5 days ☐ 6 days ☐ 7 days ☐ Other _____
7. Employer's name and address _____

INJURY

8. (a) Were you injured in the line of duty in the jurisdiction of your own ambulance district or political subdivision? ☐ Yes ☐ No
   (b) If you were injured in the line of duty involving assistance call from another locality, give name of other ambulance district or political subdivision _____

PLACE AND TIME

9. Address where injury occurred _____ County _____
10. Date of injury _____ at _____ o'clock _____ M

NATURE AND EXTENT OF INJURY

11. State full nature and cause of injury _____
12. Has injury resulted in amputation? ☐ Yes ☐ No If yes, describe _____
13. On what date did you stop work because of this injury? _____
14. Have you returned to work? ☐ Yes ☐ No If yes, give date _____
15. (a) Does injury keep you from work? ☐ Yes ☐ No (b) Have you done any work during your disability? ☐ Yes ☐ No

MEDICAL CARE

16. (a) Did you receive medical care? ☐ Yes ☐ No (b) Are you now receiving medical care? ☐ Yes ☐ No
17. (a) Are you now in need of medical care? ☐ Yes ☐ No (b) Name and address of attending doctor _____
18. If you were treated in a hospital, give name and address _____

VOLUNTEER FIREFIGHTERS' BENEFITS

19. Have you received volunteer firefighters' benefits payments for the injury reported above? ☐ Yes ☐ No
20. Are you now receiving volunteer firefighters' benefits payments? ☐ Yes ☐ No
21. Do you claim further volunteer firefighters' benefits payments? ☐ Yes ☐ No If yes, explain _____

NOTICE

22. Have you given Notice to Liable Political Subdivision of Volunteer Firefighter Injury or Death (Form VF-1) to the political subdivision liable for the payment of your volunteer firefighter benefits? ☐ Yes ☐ No If yes, was such Notice delivered personally? ☐ Yes ☐ No or sent by Registered Mail? ☐ Yes ☐ No If yes, to whom was Notice delivered/sent _____ Date _____
   Name of Officer and Political Subdivision

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.

I certify that copy of this was filed with _____ Name of Officer _____ Title of Officer
Sullivan County Risk Management Office on _____

Dated _____ Signed by _____ Volunteer Firefighter or

Signed _____ A person on their behalf, or in case of death, by any one or more of their dependents, or person on their behalf. Relationship Telephone No.

VF-3 (6-22)

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