WORKERS' COMPENSATION BOARD

State of New York - Workers' Compensation Board

Employer's First Report of Work-Related Injury/Illness

C-2F

A work-related injury or illness must be reported within 10 days (Per Section 110) of the injury/illness or be subject to a penalty. Employers are not required to submit form C-2F to the Workers' Compensation Board if the employer's insurer will be submitting the accident information electronically to the Board on the employer's behalf. If you need assistance completing this form, please contact your insurer for guidance on the best method of reporting work-related accident information. If you submit this form to the Board, please send it to P.O. Box 5205, Binghamton, NY 13902 and provide a copy to your insurer.

*Employee Name _____

WCB Case Number (JCN) _____ *Date of Injury _____

Claim Administrator Claim Number _____

INSURER / CLAIM ADMINISTRATOR INFORMATION

Insurer Name Perma c/o NEAMI Insurer ID W861223

Name Northeast Association Management, Inc.

Info/Attn _____

Address 9 Cornell Road

City Latham State NY

Postal Code 12110-6407 Country _____

Claim Admin ID T900004

EMPLOYEE INFORMATION

*First Name _____ *Middle Name/Initial _____

*Last Name _____ *Suffix _____

*Mailing Address _____

*City _____ *State _____

*Postal Code _____ Country _____

Phone Number _____ Date of Hire _____

*Date of Birth _____ *Gender ☐ Male ☐ Female ☐ Unknown

*Employee SSN _____

*Occupation Description _____

Fields marked with an asterisk [*] are required.

CLAIM INFORMATION

Time of Injury _____ ***Date Employer Had Knowledge of the Injury** _____

***Employment Status** _____ **Date Employer Had Knowledge of Date of Disability** _____

***Estimated Weekly Wage** _____ ***Number of Days Worked Per Week** _____

EMPLOYEE INJURY

***Full Wages Paid for Date of Injury** ☐ Yes ☐ No **Employer Paid Salary in Lieu of Compensation** ☐ Yes ☐ No

***Initial Treatment** ☐ No Medical Treatment ☐ Minor On-Site Treatment By Employer ☐ Minor Clinic/Hospital Treatment
☐ Emergency Evaluation ☐ Hospitalization Greater Than 24 Hours ☐ Future Major Medical/Lost Time Anticipated

Death Result of Injury ☐ Yes ☐ No ☐ Unknown **Date of Death** _____ **Number of Dependents** _____

***Nature of Injury** (i.e. Laceration, Burns, Fracture, Strain, etc) _____

***Part of Body** (i.e. left arm, right foot, head, multiple, etc) _____

***Cause of Injury** (i.e. Motor Vehicle, Machine, Strain or Injury by lifting, etc) _____

***Accident/Injury Description** (see instructions)

WORK STATUS

Initial Date Last Day Worked _____ **Return To Work Type** ☐ Actual ☐ Released

Initial Date Disability Began _____ **Physical Restrictions** ☐ Yes ☐ No

Initial Return to Work Date _____ **Return To Work Same Employer** ☐ Yes ☐ No

ACCIDENT LOCATION AND WITNESSES

***Premises** (see instructions) ☐ Employer ☐ Lessee ☐ Other

***Organization Name** _____

***Street** _____ ***State** _____

***City** _____ ***Postal Code** _____

***County** _____ **Country** _____

Location Narrative _____

Witnesses **Business Phone Number**

EMPLOYER INFORMATION

*Name _____ *Employer FEIN _____

UI Number _____ *Manual Classification Code _____

Industry Code _____

Info/Attn _____

*Mailing Address _____

*City _____ *State _____

*Postal Code _____ Country _____

Physical Addr _____

City _____ State _____

Postal Code _____ Country _____

*Contact Name _____

*Contact Business Phone Number _____

INSURED INFORMATION

*Insured Name _____ *Insured FEIN _____

Insured Type ☐ Insured ☐ Self-Insured ☐ Uninsured Insured Location ID _____

Policy Number ID _____

Policy Effective Date _____ Policy Expiration Date _____

An employer or carrier, or any employee, agent, or person acting on behalf of an employer or carrier, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

The above information is true to the best of my knowledge and belief.

If prepared by the employer:

*Signature of Person Preparing Form _____ *Date _____

*Print Name _____

Title _____ *Phone Number _____

State of New York – Workers' Compensation Board

Instructions for Completing Form C-2F
"Employer's First Report of Work-Related Injury/Illness"

Enter the name of the injured employee at the top of the report. Fill out the Date of Injury/Illness, to the best of your knowledge. If you do not have or know the Workers' Compensation Board Case Number or Claim Administrator Claim Number, please leave the corresponding field blank. It is not required to process the form.

Highlighted instructions are for volunteer firefighters and ambulance workers.

Insurer / Claim Administrator Information:

- **Insurer Name** – the name of your Workers' Compensation Insurer or Self-Insured Group name.
- **Insurer ID** – Carrier Code Number (**W** Number) issued by the Workers' Compensation Board. If you do not know the **W** number, contact your insurer.
- **Name** – the name of the Claim Administrator (claim adjusting office handling the claim).
- **Info/Attn** –any additional pertinent contact information for the Claim Administrator.
- **Address, City, State, Postal Code, & Country** – address of claims administrator, if known.
- **Claim Admin ID** – Carrier Code Number (**W** Number) or Third Party Administrator Number (**T** Number) issued by the Workers' Compensation Board. If you do not know the Third Party Administrator Number (**T** Number), contact your Claim Administrator.

Employee Information:

- **First Name, Middle Initial, Last Name, Suffix** – the injured employee's full legal name.
- **Mailing Address, City, State, Postal Code, & Country** – the full address of the injured employee.
- **Phone Number** – the employee's phone number including area code.
- **Date of Hire** - the date the employee was hired.
- **Date of Birth** – the employee's date of birth.
- **Gender** – check the appropriate gender.
- **Employee SSN** – the employee's Social Security Number (SSN).
- **Occupation Description** – identify employee's primary occupation at the time of accident

Claim Information:

- **Time of Injury** – the time when the injury/illness occurred.
- **Date Employer Had Knowledge of the Injury** – the date the employer had knowledge of the injury/illness.
- **Employment Status** – the applicable employment status for the employee (i.e. full time, part time, seasonal, volunteer, etc.).
- **Date Employer Had Knowledge of Date of Disability** – the date the employer was notified or became aware of employee's work related disability/incapacity.
- **Estimated Weekly Wage** – enter the employee's average weekly gross pay before the injury/illness.
- **Number of Days Worked Per Week** – enter the number of regularly scheduled workdays per week (1-7).

Employee Injury:

- **Full Wages Paid for Date of Injury** – check *Yes* or *No*.
- **Employer Paid Salary in Lieu of Compensation** – check *Yes* or *No* to indicate if the employee continued to receive pay after the illness/injury, such as sick leave or disability pay.
- **Initial Treatment** – check the initial treatment type.
- **Death Result of Injury** – check *Yes*, *No* or *Unknown* to indicate if the injury/illness resulted in death.
- **Date of Death** – indicate the date of death, if applicable.
- **Number of Dependents** – the number of dependents, *if known (for death cases only).*
- **Natures of Injury** - indicate the type of injury (i.e. Laceration, Burns, Fracture, Strain, etc.).
- **Part of Body** – indicate the part of body that was injured (i.e. left arm, right foot, head, multiple, etc.).
- **Causes of Injury** - indicate what caused the injury (i.e. Motor Vehicle, Machine, Strain or Injury by lifting, etc.).
- **Accident/Injury Description** – describe how the accident occurred and the resulting injuries.

Work Status:

- **Initial Date Last Day Worked** – the last day worked prior to lost time.
- **Return to Work Type** – check *Actual* for employee actually returned to work, or check *Released* for employee was released to work but did not do so.
- **Initial Date Disability Began** – Please disregard. PERMA will calculate this date. ~~od requirement has been met. If the employee was a Volunteer A~~ ~~waiting period.~~
- **Physical Restrictions** – check *Yes* if the employee has returned to work with restrictions; check *No* if the employee has returned to work without restrictions.
- **Initial Return to Work Date** – if the employee has returned to work, indicate the initial return to work date.
- **Return to Work Same Employer** – check *Yes* or *No*.

Accident Location and Witnesses:

- **Premises** – check appropriate location where injury occurred. *Employer*-accident occurred on employer's premises; *Lessee*-accident occurred on the premises of the lessee for which the employee was hired to work; or *Other*-accident occurred at a location other than the employer for which the employee was hired to work. Check *Employer*, if employee was a member of a Volunteer Ambulance Service or a Volunteer Fire Department and was injured while working for his/her own service/department. Check *Other*, if the employee was injured working in an official capacity for a Volunteer Ambulance Service or Volunteer Fire Department other than the one he/she was a member of.
- **Organization Name** – the name of the organization where the injury/illness occurred.
- **Street, City, State, Postal Code, County, & Country** – the address where the injury/illness occurred.
- **Location Narrative** – provide any additional description of the location (i.e. Building C, 4th Floor in Room 101).
- **Witnesses & Business Phone Number** – indicate the names and business phone numbers of any witnesses to the injury/illness.

Employer Information:

- **Name** – the name of the company or the owner's name and DBA name. If the employee was member of a Volunteer Ambulance Service or Volunteer Fire Department, the name of the Political subdivision should be entered.
- **Employer FEIN** – your Federal Employer Identification Number (FEIN). This is your Federal Tax ID number. If you do not have a FEIN, enter your Social Security Number. If the employer was a Volunteer Ambulance Service or Volunteer Fire Department, the FEIN of the Political subdivision should be entered.
- **UI Number** – enter the first 7 digits of your New York Unemployment Insurance (NY UI) Registration Number (UIER). This is the number used to report to the Department of Labor.
- **Manual Classification Code** – the New York Compensation Insurance Rating Board (NYCIRB) manual classification code, if known. This can be found on your workers' compensation insurance policy.
- **Industry Code** – the North American Industry Classification System (NAICS). If you do not know your NAICS, please describe the type or nature of business as accurately as possible (e.g., Restaurant, Construction, Retail).
- **Info/Attn** – indicate any additional pertinent contact information for the employer.
- **Mailing Address, City, State, Postal Code, & Country** – the employer's main address where you receive mail (such as a central office). Include P.O. Boxes.
- **Physical Address, City, State, Postal Code, & Country** – the physical address of the employer (if different).
- **Supervisor Name** & **Supervisor Business Phone Number** – indicate the name and phone number for the employee's direct supervisor, including area code.

Insured Information:

- **Insured Name** – the name of the insured entity. If the employee was a member of a Volunteer Ambulance Service or a Volunteer Fire Department, the name of the ambulance service or fire department should be entered.
- **Insured FEIN** – the Insured's Federal Employer Identification Number (FEIN). This is your Federal Tax ID number. If you do not have a FEIN, enter your Social Security Number. If the insured is a Volunteer Ambulance Service or Volunteer Fire Department the FEIN of the ambulance service or fire department should be entered.
- **Insured Location ID** – indicate the Insured Location ID, if any (i.e. Store 202, Jobsite 51, etc.).
- **Insured Type** – check the insurance arrangement: *Insured*, *Self-Insured*, or *Uninsured*.
- **Policy Number ID** – your Workers' Compensation Insurance Policy Number.
- **Policy Effective** & **Expiration Date** – the policy effective and expiration dates.