



Allegany County Mutual Self Insured

Worker's Compensation Plan

Claim Contacts

Allegany County:

Jodi Adams - Assistant to the Allegany County Administrator

Phone: 585-268-9217

Fax: 585-268-9623

E-mail: adamsjm@alleganyco.com

Richardson & Stout, Inc:

Kathy Smith – Claims Manager

Phone: 585-593-0991 x 307

Fax: 585-593-4296

E-mail: ksmith@rsinsurance.com

**If you are advised that Kathy Smith is unavailable
request that someone else help you in her absence**

POMCO:

Lost Time Claims

Anita Hoare

Senior Claims Adjuster

Phone: 877-237-7475 x 44478

Fax: 315-433-5473

E-mail: ahoare@pomco.com

Medical Only Claims

Michele Potts

Medical Only Claims Adjuster

Phone: 877-237-7475 x 44361

Fax: 315-433-5473

E-mail: mpotts@pomco.com



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Claim Reporting Procedure –Volunteer Fire Fighters

To achieve our goal to provide the best possible service to an injured volunteer and to avoid a penalty imposed by the Worker's Compensation Board, any injury that occurs while in the line of duty as a volunteer fire fighter must be reported within **10 days** of the date of injury. Please follow the outlined procedures to insure timely reporting and processing of a Worker's Compensation claim.

1. **As soon as an injury is reported** by a volunteer fire fighter, the **injured volunteer** will need to complete the **VF-1 form** and the **fire chief, officer or designated superior** will need to complete the **VF-2 form**. The forms must be signed, dated and contact information provided.
2. The **VF-3** form must be provided to the **injured volunteer** or a person on his/her behalf, for completion.
3. **Once the forms are completed**, refer to the Claim Contacts sheet and forward by **Fax or E-mail the completed VF-1, VF-2 and VF-3 forms to Jodi Adams at Allegany County**. **Do NOT send ANY forms direct to the Worker's Compensation Board**. If the VF-3 cannot be completed by the injured volunteer immediately, submit the VF-1 and VF-2 as soon as possible and **within the 10 day** requirement.



4. When the VF-3 is returned by the injured volunteer, make sure it is signed and dated by the fire chief, officer or designated superior for the organization, as well as by the injured volunteer or person on his/her behalf. If possible, the VF-3 should be submitted with the VF-1 and VF-2. However, when this is not possible and it has to be submitted separately, please refer to the Claim Contacts sheet and submit this to Kathy Smith at Richardson & Stout by Fax or E-mail.
5. Jodi Adams at Allegany County will forward the initial claim forms to POMCO, who will administer the claim. Jodi Adams at Allegany County and Kathy Smith at Richardson & Stout will be provided an Event or Claim number by POMCO. It is at this point that Kathy Smith at Richardson & Stout will provide the designated contacts with claim number and handler information. She will be able to assist the injured volunteer with any issues that cannot be resolved through direct contact with the POMCO handler.
6. The claim will have an **EVENT number** if there is **no lost time** from the injured volunteer's regular employment **or medical treatment** sought by the volunteer. The claim will be given a **CLAIM number** if the volunteer, as a result of the injury, is **caused to lose time** from his/her regular employment and/or **has to seek medical treatment** as a result of the injury.
7. The injured volunteer will be contacted by the POMCO representative assigned to handle the claim. Refer to the Claim Contacts sheet for the primary POMCO claim contacts for lost time and medical only claims.

WE ARE HERE TO HELP YOU!

Please contact Richardson & Stout with any questions regarding these procedures or the completion of forms. It is the goal of Allegany County, Richardson & Stout & POMCO to handle each and every claim fairly and in a timely manner.

**STATE OF NEW YORK-WORKERS' COMPENSATION BOARD
POLITICAL SUBDIVISION'S REPORT OF INJURY TO VOLUNTEER FIREFIGHTER**

Send this Report directly to Chair, Workers' Compensation Board at address shown on reverse side within ten (10) days after injury is incurred. Answer all questions fully. Copy also should be provided to or retained by your insurance carrier.

Any political subdivision that fails to timely file Form VF-2, as required by Section 110 of the Workers' Compensation Law and Section 42 of the Volunteer Firefighters' Benefit Law, shall be subject to a fine of not more than \$1,000. In addition, the Board or Chair may impose a penalty of up to \$2,500.

TYPEWRITER PREPARATION IS STRONGLY RECOMMENDED - INCLUDE ZIP CODE IN ALL ADDRESSES-VOLUNTEER FIREFIGHTER'S S.S.NO. MUST BE ENTERED BELOW

WCB CASE NO. (If Known)	CARRIER CASE NO.	CARRIER CODE NO. WV-802003	VF POLICY NO.	SOCIAL SECURITY NO.
NAME		ADDRESS		
1. POLITICAL SUBDIVISION OR FIRE DISTRICT				
2. FIRE COMPANY				
3. INSURANCE CARRIER IF ANY Allegany County Mutual Self-Insurance Plan		7 Court St., Room 218. Belmont, NY 14813		
I N J U R E D	4. NAME AND ADDRESS OF VOLUNTEER FIREFIGHTER		5.(a) SEX	5.(b) DATE OF BIRTH month day year
	5. NAME AND ADDRESS OF REGULAR EMPLOYER		7. HAS INJURED FIREFIGHTER RETURNED TO REGULAR EMPLOYMENT <input type="checkbox"/> Yes <input type="checkbox"/> No	
I N J U R Y	8. WHERE DID INJURY OCCUR? (Specify in building, outside building, en route in fire truck, etc.)			
	9. CHECK ONE: <input type="checkbox"/> THE ABOVE-NAMED VOLUNTEER FIREFIGHTER WAS INJURED IN THE LINE OF DUTY WHILE SERVING WITH HIS/HER OWN FIRE COMPANY OR FIRE DEPARTMENT. <input type="checkbox"/> THE ABOVE-NAMED VOLUNTEER FIREFIGHTER, MEMBER OF ANOTHER FIRE DEPARTMENT, WAS INJURED IN LINE OF DUTY AFTER HIS/HER SERVICES HAD BEEN ACCEPTED BY THE ABOVE-NAMED FIRE COMPANY OR FIRE DEPARTMENT.			
	10. DATE OF INJURY	11. DATE DISABILITY BEGAN	12. DATE OF FIRST KNOWLEDGE OF INJURY	13. WAS NOTICE OF INJURY GIVEN IN WRITING <input type="checkbox"/> Yes <input type="checkbox"/> No
	14. ADDRESS WHERE INJURY OCCURRED		15. NAMES AND ADDRESSES OF WITNESSES (Attach separate sheet if necessary)	
	16. NATURE OF INJURY AND PART(S) OF BODY AFFECTED (e.g., "INJURY TO CHEST", etc.)			17. DID YOU PROVIDE MEDICAL CARE? IF YES, WHEN <input type="checkbox"/> Yes <input type="checkbox"/> No
	18. (a) NAME AND ADDRESS OF DOCTOR		(b) NAME AND ADDRESS OF HOSPITAL	
C A U S E O F I N J U R Y	19. WHAT WAS FIREFIGHTER DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material firefighter was using.)			
	20. HOW DID THE INJURY OR EXPOSURE OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. Please use separate sheet if necessary.)			
	21. (a) WAS PROTECTIVE EQUIPMENT PROVIDED. (Such as gas mask, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No		(b) WAS PROTECTIVE EQUIPMENT IN USE AT THE TIME? <input type="checkbox"/> Yes <input type="checkbox"/> No	
(c) WAS PROTECTIVE EQUIPMENT DEFECTIVE? <input type="checkbox"/> Yes <input type="checkbox"/> No		d. IN WHAT WAY (Attach separate sheet if necessary).		
F A T A L C A S E S	22. (a) DATE OF DEATH	(b) NAME AND ADDRESS OF NEAREST RELATIVE		(c) RELATIONSHIP
	DATE OF THIS REPORT			
P R E P A R A T I O N	IF FORM IS SUBMITTED BY POLITICAL SUBDIVISION, COMPLETE A & B BELOW. IF FORM IS SUBMITTED BY THIRD PARTY, COMPLETE A,B,C & D BELOW.			
	A. PERSON PREPARING FORM OR SUPPLYING INFORMATION TO THIRD PARTY		B. TITLE	TELEPHONE NUMBER & EXTENSION
	C. IF REPORT PREPARED BY THIRD PARTY, COMPANY NAME AND ADDRESS			
	D. THIRD PARTY CONTACT NAME		TELEPHONE NUMBER & EXTENSION	

VF-2 (1-11)

VF-2

VF-2

VF-2

VF-2

TO BE COMPLETED BY FIRE DEPARTMENT CHIEF, OFFICER OR DESIGNATED SUPERIOR



VOLUNTEER FIREFIGHTER'S CLAIM FOR BENEFITS

SEE REVERSE FOR FILING INSTRUCTIONS

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

Form with sections: INFORMATION, REGULAR WORK, INJURY, PLACE AND TIME, NATURE AND EXTENT OF INJURY, MEDICAL CARE, VOLUNTEER FIREFIGHTERS' BENEFITS, NOTICE. Includes questions 1-22 and a disclaimer at the bottom.

I certify that copy of this was filed with Name of Officer Title of Officer on Political Subdivision or Ambulance Service Liable for Benefits Dated Signed by Volunteer Firefighter or Signed A person on his/her behalf, or in case of death, by any one or more of his/her dependents, or person on their behalf. Relationship Telephone No.