Allegany COUNTY New York

RS Richardson & Stout Inc.
*Excellence Since 1903*

# 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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## Allegany County Mutual Self Insured

## Worker's Compensation Plan

## 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.

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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

THIIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

## NOTICE TO LIABLE POLITICAL SUBDIVISION OF VOLUNTEER FIREFIGHTER'S INJURY OR DEATH

THIS NOTICE IS REQUIRED TO BE FILED WITHIN 90 DAYS AFTER THE DATE OF INJURY OR DEATH UNLESS CLAIM FOR BENEFITS, INCLUDING MEDICAL, HOSPITAL OR OTHER CARE, (VF-3 or VF-62) IS FILED WITHIN 90 DAYS AFTER THE DATE OF INJURY OR DEATH.

Sec.40 of the Volunteer Firefighters' Benefit Law provides that, unless Claim for Benefits is filed within 90 days after injury or death, Notice of such injury or death shall be given by delivery in person or by registered mail within 90 days by the injured volunteer firefighter or by any person claiming to be entitled to benefits, or by someone in his/her behalf, to the designated officer of the liable political subdivision as follows:

| If the political subdivision liable for benefits is a | Then give to |
|---|---|
| a. County | a. Clerk of the Board of Supervisors |
| b. City | b. Comptroller or Chief Financial Officer |
| c. Town | c. Town Clerk |
| d. Village | d. Village Clerk |
| e. Fire District | e. Secretary |

If your injury occured prior to March 1, 1964, the injury should be reported to the county, city, town, village or fire district for which the service was rendered whether such service was rendered for the home area or for another area under contract or in response to a call for assistance. If the injury occured on March 1, 1964 or thereafter, the home county, city, town, village or fire district is liable for thr payment of benefits regardless of whether the injury was incurred while serving your home area or an aided area. If you have any doubt concerning the liable political subdivision, a copy of this notice should be filed with all the political subdivisions involved.

THIS NOTICE IS NOT A CLAIM FOR BENEFITS. FAILURE TO FILE THE CLAIM FOR BENEFITS (FORM VF-3 or VF-62) WITHIN TWO YEARS AFTER INJURY OR DEATH MAY BAR YOU FROM RECEIVING BENEFITS.

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To: _____
Name of Officer | Title of Officer | Political Subdivision Liable for Benefits

| | | | | | |
|---|---|---|---|---|---|
| 1. VOLUNTEER FIREFIGHTER | First Name | Middle Initial | Last Name | Home Address | Apt. No. |
| | | | | | |
| 2. FIRE COMPANY | Name | | | Address | |
| | | | | | |
| 3. POLITICAL SUBDIVISION OR FIRE DISTRICT | | | | | |
| 4. REGULAR EMPLOYER, IF ANY | | | | | |

5. Address and community where injury occurred

_____

6. (a) Date of injury_____ at____o'clock____M. (b) Date of death_____

(c) Place of death_____

7. State fully nature and cause of injury or death

_____

_____

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Dated_____ Signed by_____, or
Volunteer Firefighter

Signed by_____
A person on his/her behalf, or in case of death, by any one or more of his/her dependents, or by a person on their behalf. Relationship

VF-1 (8-97)

TO BE COMPLETED BY THE VOLUNTEER FIREFIGHTER

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. | VF POLICY NO. | SOCIAL SECURITY NO. |
|---|---|---|---|---|
| | | W-802003 | | |

| | 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 |

**INJURED PERSON**

4.NAME AND ADDRESS OF VOLUNTEER FIREFIGHTER

5.(a) SEX

5.(b) DATE OF BIRTH month day year

6.NAME AND ADDRESS OF REGULAR EMPLOYER

7. HAS INJURED FIREFIGHTER RETURNED TO REGULAR EMPLOYMENT ☐ Yes ☐ No

**INJURY**

8. WHERE DID INJURY OCCUR? (Specify in building, outside building, en route in fire truck, etc.)

9. CHECK ONE: ☐ THE ABOVE-NAMED VOLUNTEER FIREFIGHTER WAS INJURED IN THE LINE OF DUTY WHILE SERVING WITH HIS/HER OWN FIRE COMPANY OR FIRE DEPARTMENT. ☐ 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 ☐ Yes ☐ 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? ☐ Ye ☐ No IF YES, WHEN

18. (a) NAME AND ADDRESS OF DOCTOR

(b) NAME AND ADDRESS OF HOSPITAL

**CAUSE OF INJURY**

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.) ☐ Yes ☐ No (b) WAS PROTECTIVE EQUIPMENT IN USE AT THE TIME? ☐ Yes ☐ No (c) WAS PROTECTIVE EQUIPMENT DEFECTIVE? ☐ Yes ☐ No 5. IN WHAT WAY (Attach separate sheet if necessary).

**FATAL CASES**

22. (a) DATE OF DEATH

(b) NAME AND ADDRESS OF NEAREST RELATIVE

(c) RELATIONSHIP

**PREPARATION**

DATE OF THIS REPORT

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



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

NEW YORK STATE | Workers' Compensation Board

# 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

| 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) Sex _____ (c) Date of Birth _____ (e) 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

_____ Political Subdivision or Ambulance Service Liable for Benefits on _____

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.

VF-3 (1-11)

TO BE COMPLETED BY THE VOLUNTEER FIREFIGHTER