

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

THIS 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

- a. County
- b. City
- c. Town
- d. Village
- e. Fire District

Then give to

- a. Clerk of the Board of Supervisors
- b. Comptroller or Chief Financial Officer
- c. Town Clerk
- d. Village Clerk
- e. Secretary

If your injury occurred 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 occurred on March 1, 1964 or thereafter, the home county, city, town, village or fire district is liable for the 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.

To: _____

Name of Officer
Title of Officer
Political Subdivision Liable for Benefits

	First Name	Middle Initial	Last Name	Home Address	Apt. No.
1. VOLUNTEER FIREFIGHTER					
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 _____

Dated _____ Signed by _____, or
Volunteer Firefighter

Signed by _____ Relationship _____

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.

**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.