NEW YORK STATE Workers' Compensation Board

WORLD TRADE CENTER VOLUNTEER'S CLAIM FOR COMPENSATION

Send completed form to:
PO Box 5205
Binghamton, NY 13902-5205

You MUST answer all questions fully - type or print clearly. Carefully read the requirements to file a claim as a World Trade Center volunteer on page two. You must provide all required documentation with this form including a letter of determination from the World Trade Center Health Program.

A. Injured Person

Last Name: _____ First Name: _____ MI: ___

Mailing Address: _____ Line 2: _____

City: _____ State: _____ Zip Code: _____ Country: _____

Daytime phone #: _____ Email Address: _____

Social Security #: _____ Date of Birth (MM/DD/YYYY): _____ Gender: ☐ M ☐ F ☐ X

Do you speak English: ☐ Yes ☐ No If No, what language do you speak: _____

B. Place/Time

What date(s) did you volunteer at or near Ground Zero or Fresh Kills Landfill (MM/DD/YYYY): _____

_____

Did a volunteer agency or a rescue entity direct your activities at Ground Zero or its vicinity or Fresh Kills Landfill: ☐ Yes ☐ No

If Yes, name of agency or entity: _____

If No, who can provide a statement to support participation in WTC rescue, recovery, or clean up: _____

C. Nature and Extent of Injury/Illness

How did the injury/illness occur: _____

_____

State fully the nature of your injury/illness, including all parts of body injured: _____

_____

Did you stop regular work because of this injury/illness: ☐ Yes ☐ No If Yes, date stopped (MM/DD/YYYY): _____

If you stopped regular work, have you returned to work: ☐ Yes ☐ No If Yes, date returned (MM/DD/YYYY): _____

Name of Regular Employer: _____

Address of Regular Employer: _____

D. Benefits/Medical Care

Have you applied for benefits from the September 11th Victim Compensation Fund: ☐ Yes ☐ No

If Yes, give the status of your claim: _____

Did you receive or are you now receiving medical care: ☐ Yes ☐ No Are you now in need of medical care: ☐ Yes ☐ No

Name of Attending Doctor: _____

Doctor's Address: _____

If you were in a hospital, give the dates hospitalized (MM/DD/YYYY): _____

Name of Hospital: _____

Hospital's Address: _____

Did you incur any out-of-pocket expenses for medical care to treat the injury/illness sustained: ☐ Yes ☐ No

If Yes, what is the total amount of out-of-pocket expenses incurred: $ _____

I hereby present my claim for compensation for injury/illness resulting from volunteer work at Ground Zero or its vicinity or Fresh Kills Landfill, and in support of it I make the foregoing statement facts.

_____ _____

Injured Person Signature (Claimant) Date

Any person 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.

Important Information to the Claimant
World Trade Center Volunteer's Claim for Compensation (Form WTCVol-3)

Funds are available to compensate volunteers injured or disabled while providing assistance to New Yorkers following the September 11, 2001, terrorist attack on the World Trade Center. These funds are known as the New York State World Trade Center Volunteer Fund. The New York State Workers' Compensation Board will receive claims from volunteers suffering illness or injury resulting from volunteering at the World Trade Center site or the Fresh Kills landfill, and will administer payments from the fund in accordance with the Workers' Compensation law and Board rules. By completing, signing and filing this form, you are making a claim against the New York State World Trade Center Volunteer Fund.

Please note that the benefits for all World Trade Center volunteers are limited to the continued existence of the funding provided through the New York State World Trade Center Volunteer Fund.

In order to document your claim, submit this form with the following copies to the New York State Workers' Compensation Board:

1. Proof of volunteer status (letter of commendation/confirmation from the agency that directed your September 11th volunteer activities at Ground Zero or Fresh Kills Landfill; pictures, witness letters, etc).
2. Medical evidence of a causally related injury or illness from volunteering at a designated site.
3. Completed WTC-12 form (Registration of participation in World Trade Center rescue, recovery, or clean-up operations).
4. Letter of acceptance or denial from the World Trade Center Health Program. The Board now requires that volunteer workers file a claim with the World Trade Center Health Program before filing a claim with the Board; the benefit letter from the World Trade Center Health Program should be submitted along with the WTCVol-3.
5. If you have submitted a claim to the Victim Compensation Fund, provide the most recent eligibility determination letter, award letter, or other notice of claims status.
6. Completed WTC HIPAA release form - wcb.ny.gov/content/main/forms/wtc-hipaa.pdf
7. Completed Victim Compensation Fund release form - wcb.ny.gov/content/main/forms/wtc-vcf_auth.pdf

Please keep all documentation for your records.

Please notify your health provider(s) that you have a pending claim with the New York State World Trade Center Volunteer Fund administered by the Workers' Compensation Board and that their bills and medical reports are to be sent to the New York State Workers' Compensation Board, No Insurance Unit, PO Box 5205, Binghamton, NY 13902-5205.

Notification Pursuant to the New York Personal Privacy Protection Law
(Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 552a).
The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

HIPAA NOTICE
In order to adjudicate a workers' compensation claim or disability, WCL-13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the insurance carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.