Workers' Compensation Reporting and Claim Procedures

City of Mount Vernon
New York

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The Workers' Compensation Incident Reporting, Claims Process and Return-to-Work Procedures

!Important! The Workers' Compensation claim process is a guide to ensure all work injuries are reported efficiently and timely. The employer must notify TRIAD within 10 days from the incident. Failure to file the claim within 10 days after the accident, will result in the City receiving a penalty.

❶ Immediate Reporting & Medical Assistance

The employee must report any workplace incident to their supervisor immediately. If necessary, appropriate medical assistance should be sought without delay.

❷ Supervisor's Responsibilities

The supervisor is responsible for completing an internal incident report and the NYS Workers' Compensation Form C-2F.

❸ Submission of Documentation

The designated department representative must submit the incident report and C-2F form to both Human Resources and the Employee Benefits office within 24 hours of the incident.

Important: All documentation must be delivered in person to safeguard employee privacy and ensure HIPAA compliance (e.g., avoid emailing documents containing Social Security numbers).

❹ Claim Initiation

The Employee Benefits office will initiate the claim by submitting the completed C-2F form to Triad (the Workers' Compensation carrier) and will notify HR upon successful submission.

❺ Medical Documentation

The employee must provide all relevant medical documentation to HR. The physician's note must clearly indicate whether the employee is fit to resume work duties or requires medical leave.

❻ Notification of Required RPC

Upon receipt of the physician's note, HR will inform the supervisor if a Request Personnel Change (RPC) form is required. The department must submit the RPC to HR within 24–48 business hours. HR will then submit the RPC to Civil Service, Payroll and update the Employee Benefits office with the employee's status.

❼ Ongoing Claim Monitoring

The Employee Benefits office will continue to work with Triad to monitor the status and progress of the employee's Workers' Compensation claim.

❽ Return-to-Work Process

The employee must submit return-to-work documentation to both HR and their department head within 24–48 business hours of their clearance.

HR and the department head will review and assess any restrictions, limitations, or job accommodations required, and confirm the employee's return-to-work date.

❾ Final RPC Submission

Once a return-to-work date is established, the supervisor must submit an updated RPC to HR within 24–48 business hours to reflect the employee's updated status. HR will submit the updated RPC to Civil Service, Payroll and update the Employee Benefits office with the employee's updated status.

❿ Closure of Worker's Compensation Claim

The Employee Benefits office will coordinate with Triad's closure of claim and process any outstanding payments.

The Workers' Compensation Claim Process is subject to change, based on the Comptroller's discretion

INCIDENT REPORT FORM

Your Name: ______________________________ Date: _________________________

Title: ___________________________________ Phone Number: ________________

Department: ______________________________

Status: ____Employee ____Contractor

Other (Specify) __________________________

Address: ____

Complaint Information

Date of Incident: _______________ Time of Incident: ______________

Location of Incident: ____

Please describe the incident in detail:

____

____

____

____

____

____

If there are others who have witnessed the incident, please provide their names and phone numbers below:

____

____

____

Is this the first time you have raised this concern about this person?

____ Yes ____ No

Do you have any suggestions for resolving the complaint? If so, please explain.

____

____

____

Do you have any additional information or complaints? If so, please explain.

____

____

____

Signature: ________________________________ Print Name: __________________________

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 ______________ **Insurer ID** ______________

Name TRIAD GROUP

Info/Attn ______________

Address 185 JORDAN RD

City TROY **State** NY

Postal Code 12180 **Country** USA

Claim Admin ID T100068

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 ______________

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** ____________

Work Week Type ☐ Standard Work Week ☐ Fixed Work Week ☐ Varied Work Week

Work Days Scheduled ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

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 CITY OF MT VERNON
Employer FEIN 136007305

UI Number 04-60117 3
Manual Classification Code ____

Industry Code 92119

Info/Attn COMPTROLLERS OFFICE

Mailing Address CITY HALL

City MT VERNON
State NY

Postal Code 10550
Country USA

Physical Addr CITY HALL

City MT VERNON
State NY

Postal Code 10550
Country USA

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 ____