TOWN OF ROTTERDAM
REPORTING VFBL CLAIMS EFFECTIVE 04/01/2025

- **FIRST REPORT C 2F IS E MAILED TO:**
  WCReporting@wrightinsurance.com
  OR FAXED TO:
  516 794 5254 (E Mail Preferred)

- **SEND COPIES OF FIRST REPORT C 2F TO**
  Michael Karl, USI Insurance Services
  Michael.karl@USI.com
  Phone: 518 514 3629
  AND
  Morgan Coryer, Personnel and Benefits Coordinator
  MCoryer@rotterdamny.org
  Phone: 518 355 7575 Ext. 361

- **For follow up documents or claim inquiries: Nicole Andrews, Claims Examiner, NYS Municipal Workers Compensation Alliance Phone 516 767 6022**
  E Mail NAndrews@wrightinsurance.com

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 Wright Risk Management **Insurer ID** W848139

Name NYS Municipal Workers Comp Alliance

Info/Attn Workers' Compensation Claims Department

Address 333 Earle Ovington Blvd., Suite 505

City Uniondale **State** NY

Postal Code 11553 **Country** USA

Claim Admin ID T100094

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 _____ Employer FEIN _____

UI Number _____ Manual Classification Code _____

Industry Code _____

Info/Attn _____

Mailing Address _____

City _____ State _____

Postal Code _____ Country _____

Physical Addr _____

City _____ State _____

Postal Code _____ Country _____

Contact Name _____

Contact Business Phone Number _____

INSURED INFORMATION

Insured Name Town of Rotterdam Insured FEIN 146002410

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 _____