Union Center Fire Company, Inc.

PO Box 8800 Endicott, NY 13762-8800
Business: 607-748-1321 • Fax: 607-953-4273

May 4, 2014

First, notify a person in your chain of command (normally an officer) on the day of your injury, regardless of whether you seek medical attention.

Use the forms in this package as follows.

- PERMA Accident Notification Form -- for injuries that resulted in no lost time, and are unlikely to result in a medical provider bill
- C-2F Form -- for injuries that resulted in lost time or a medical provider bill
- C-2F Instructions -- for completing the C-2F form
- PERMA First Fill Temporary Pharmacy Card -- for 10 days of prescription drug coverage before a pharmacy card is issued

Employer Information
Union Center Fire Company, Inc.
c/o Town of Union
3111 East Main Street
Endwell, NY 13760-5990
(607) 786-2938

Insurance Carrier
Public Employer Risk Management Association, Inc.
c/o Northeast Association Management, Inc.
P.O. Box 12250
Albany, NY 12212-2250
(888)737-6269

Carrier ID No.: W861223

Deliver the forms to the Town of Union Human Resources Department or fax them there at 754-2855. They will handle the rest with our insurance carrier.

PERMA

PUBLIC EMPLOYER RISK MANAGEMENT ASSOCIATION, INC.
9 Cornell Road, Latham, NY 12110
Toll Free in US: 888-737-6269 • Fax: 1-877-737-6232 • Email: *compforms@neami.com*

Managed by **NORTHEAST ASSOCIATION MANAGEMENT, INC.**

ACCIDENT NOTIFICATION FORM

*For injuries that required **first aid only***

COMPLETE AND SUBMIT THIS FORM WITHIN 24 HOURS OF ACCIDENT
IF POSSIBLE, PLEASE SUBMIT THIS FORM ONLINE AT *www.perma.org*.
If not possible, please fax form to above number, or email to compforms@neami.com.
The C2-F form can be filed in lieu of this form, and must be filed if the injury required more than first aid treatment, in accordance with Section 110 of NYS Workers' Compensation Law.
For coverage questions, please feel free to contact PERMA at the above address or phone number.

TO BE COMPLETED BY SUPERVISOR

(Please print)

Injured Person:______________________________ Sex: M ☐ F ☐

Employer's or Volunteer District's Name:______________________________

Home address:______________________________ Apt. #__________

City:______________________________ State:______________ Zip:____________

Home phone #: (____)__________________ **SS#**:______________________ DOB:________________

Dept:____________________ Job title:______________________ Dept. code (see reverse side): __________

Volunteer ☐ **Paid** ☐ If volunteer, who is your regular employer?______________________________

Employer contact name: ______________________ Employer contact phone #: (____)__________________

Injury Date:____/____/____ Injury Time:________AM / PM Date employer notified: ____/____/____

Witness Name: ______________________________

Description of injury, including body part injured and how injury occurred: ______________________________

____

____

Where did injury/accident occur? ______________________________

____

Describe medical treatment – **If the injured person required treatment beyond first aid, please file a C-2F form within 10 days of notice**: ___

____

____

Has employee returned to work? Yes ☐ No ☐ Return to work date: ________/________/________ Actual ☐ Expected ☐

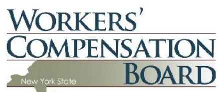
Weekly wage: ______________________ PT ☐ FT ☐ Will wages be continued during disability? Yes ☐ No ☐

Based on restriction, the employee will be assigned the following status: Full Duty ☐ Transitional Duty ☐

Supervisor:______________________________ Phone #:______________________

Supervisor's Signature:______________________________ Date: ______/______/______

PROVIDE A COPY OF THIS FORM TO: Injury Coordinator, Department, and Employee



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: Perma c/o NEAMI | Insurer ID: W861223

Name: Northeast Association Management, Inc.

Info/Attn: ______

Address: 9 Cornell Road

City: Latham | State: NY

Postal Code: 12110-6407 | Country: ______

Claim Admin ID: T900004

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 ______

Fields marked with an asterisk [*] are required.

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 ______

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 ____ *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 ____

State of New York – Workers' Compensation Board

Instructions for Completing Form C-2F
"Employer's First Report of Work-Related Injury/Illness"

Enter the name of the injured employee at the top of the report. Fill out the Date of Injury/Illness, to the best of your knowledge. If you do not have or know the Workers' Compensation Board Case Number or Claim Administrator Claim Number, please leave the corresponding field blank. It is not required to process the form.

Highlighted instructions are for volunteer firefighters and ambulance workers.

Insurer / Claim Administrator Information:

- **Insurer Name** – the name of your Workers' Compensation Insurer or Self-Insured Group name.
- **Insurer ID** – Carrier Code Number (**W** Number) issued by the Workers' Compensation Board. If you do not know the **W** number, contact your insurer.
- **Name** – the name of the Claim Administrator (claim adjusting office handling the claim).
- **Info/Attn** –any additional pertinent contact information for the Claim Administrator.
- **Address, City, State, Postal Code, & Country** – address of claims administrator, if known.
- **Claim Admin ID** – Carrier Code Number (**W** Number) or Third Party Administrator Number (**T** Number) issued by the Workers' Compensation Board. If you do not know the Third Party Administrator Number (**T** Number), contact your Claim Administrator.

Employee Information:

- **First Name, Middle Initial, Last Name, Suffix** – the injured employee's full legal name.
- **Mailing Address, City, State, Postal Code, & Country** – the full address of the injured employee.
- **Phone Number** – the employee's phone number including area code.
- **Date of Hire** - the date the employee was hired.
- **Date of Birth** – the employee's date of birth.
- **Gender** – check the appropriate gender.
- **Employee SSN** – the employee's Social Security Number (SSN).
- **Occupation Description** – identify employee's primary occupation at the time of accident

Claim Information:

- **Time of Injury** – the time when the injury/illness occurred.
- **Date Employer Had Knowledge of the Injury** – the date the employer had knowledge of the injury/illness.
- **Employment Status** – the applicable employment status for the employee (i.e. full time, part time, seasonal, volunteer, etc.).
- **Date Employer Had Knowledge of Date of Disability** – the date the employer was notified or became aware of employee's work related disability/incapacity.
- **Estimated Weekly Wage** – enter the employee's average weekly gross pay before the injury/illness.
- **Number of Days Worked Per Week** – enter the number of regularly scheduled workdays per week (1-7).

Employee Injury:

- **Full Wages Paid for Date of Injury** – check *Yes* or *No*.
- **Employer Paid Salary in Lieu of Compensation** – check *Yes* or *No* to indicate if the employee continued to receive pay after the illness/injury, such as sick leave or disability pay.
- **Initial Treatment** – check the initial treatment type.
- **Death Result of Injury** – check *Yes*, *No* or *Unknown* to indicate if the injury/illness resulted in death.
- **Date of Death** – indicate the date of death, if applicable.
- **Number of Dependents** – the number of dependents, *if known (for death cases only).*
- **Natures of Injury -** indicate the type of injury (i.e. Laceration, Burns, Fracture, Strain, etc.).
- **Part of Body** – indicate the part of body that was injured (i.e. left arm, right foot, head, multiple, etc.).
- **Causes of Injury -** indicate what caused the injury (i.e. Motor Vehicle, Machine, Strain or Injury by lifting, etc.).
- **Accident/Injury Description** – describe how the accident occurred and the resulting injuries.

Work Status:

- **Initial Date Last Day Worked** – the last day worked prior to lost time.
- **Return to Work Type** – check *Actual* for employee actually returned to work, or check *Released* for employee was released to work but did not do so.
- **Initial Date Disability Began** – Please disregard. PERMA will calculate this date. ~~od requirement has been met. If the employee was a Volunteer A~~ ~~waiting period.~~
- **Physical Restrictions** – check *Yes* if the employee has returned to work with restrictions; check *No* if the employee has returned to work without restrictions.
- **Initial Return to Work Date** – if the employee has returned to work, indicate the initial return to work date.
- **Return to Work Same Employer** – check *Yes* or *No*.

Accident Location and Witnesses:

- **Premises** – check appropriate location where injury occurred. *Employer*-accident occurred on employer's premises; *Lessee*-accident occurred on the premises of the lessee for which the employee was hired to work; or *Other*-accident occurred at a location other than the employer for which the employee was hired to work. Check *Employer*, if employee was a member of a Volunteer Ambulance Service or a Volunteer Fire Department and was injured while working for his/her own service/department. Check *Other,* if the employee was injured working in an official capacity for a Volunteer Ambulance Service or Volunteer Fire Department other than the one he/she was a member of.
- **Organization Name** – the name of the organization where the injury/illness occurred.
- **Street, City, State, Postal Code, County, & Country** – the address where the injury/illness occurred.
- **Location Narrative** – provide any additional description of the location (i.e. Building C, 4th Floor in Room 101).
- **Witnesses & Business Phone Number** – indicate the names and business phone numbers of any witnesses to the injury/illness.

Employer Information:

- **Name** – the name of the company or the owner's name and DBA name. If the employee was member of a Volunteer Ambulance Service or Volunteer Fire Department, the name of the Political subdivision should be entered.
- **Employer FEIN** – your Federal Employer Identification Number (FEIN). This is your Federal Tax ID number. If you do not have a FEIN, enter your Social Security Number. If the employer was a Volunteer Ambulance Service or Volunteer Fire Department, the FEIN of the Political subdivision should be entered.
- **UI Number** – enter the first 7 digits of your New York Unemployment Insurance (NY UI) Registration Number (UIER). This is the number used to report to the Department of Labor.
- **Manual Classification Code** – the New York Compensation Insurance Rating Board (NYCIRB) manual classification code, if known. This can be found on your workers' compensation insurance policy.
- **Industry Code** – the North American Industry Classification System (NAICS). If you do not know your NAICS, please describe the type or nature of business as accurately as possible (e.g., Restaurant, Construction, Retail).
- **Info/Attn** – indicate any additional pertinent contact information for the employer.
- **Mailing Address, City, State, Postal Code, & Country** – the employer's main address where you receive mail (such as a central office). Include P.O. Boxes.
- **Physical Address, City, State, Postal Code, & Country** – the physical address of the employer (if different).
- **Supervisor Name** & **Supervisor Business Phone Number** – indicate the name and phone number for the employee's direct supervisor, including area code.

Insured Information:

- **Insured Name** – the name of the insured entity. If the employee was a member of a Volunteer Ambulance Service or a Volunteer Fire Department, the name of the ambulance service or fire department should be entered.
- **Insured FEIN** – the Insured's Federal Employer Identification Number (FEIN). This is your Federal Tax ID number. If you do not have a FEIN, enter your Social Security Number. If the insured is a Volunteer Ambulance Service or Volunteer Fire Department the FEIN of the ambulance service or fire department should be entered.
- **Insured Location ID** – indicate the Insured Location ID, if any (i.e. Store 202, Jobsite 51, etc.).
- **Insured Type** – check the insurance arrangement: *Insured*, *Self-Insured*, or *Uninsured*.
- **Policy Number ID** – your Workers' Compensation Insurance Policy Number.
- **Policy Effective** & **Expiration Date** – the policy effective and expiration dates.

First Fill
Temporary Pharmacy Card

Making it easy to get your workers' compensation prescriptions filled.

Just follow these easy steps...

Employer:

Immediately upon receiving notice of injury, fill in the information below and give it to your employee.

Injured Employee:

1. If you need a prescription filled for a work-related injury or illness, go to a local Tmesys network pharmacy.
2. Give this page to the pharmacist.
3. The pharmacist will fill your prescription at no cost.

tmesys®
Prescription Card

PERMA

CARRIER / TPA	EMPLOYER
PERMA	
INJURED WORKER NAME	
SOCIAL SECURITY NUMBER	DATE OF INJURY

Notice to Cardholder: This card should be presented to your pharmacy to receive medication for your work-related injury. It is only valid within 30 days of your date of injury. For information regarding the program or to find nearby pharmacies call **866.599.5426.**

Attention Pharmacists: Call **800.964.2531** to establish First Fill benefit eligibility and obtain the ID# for online adjudication of approved benefits for the injured worker.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy
Help Desk 800.964.2531

	NDC		Envoy
RxBin	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #

(To create a card for your wallet, cut along outer line and fold in half.)

Pharmacist:

1. Call the Tmesys Pharmacy Help Desk at **800.964.2531.**
2. Provide the information listed above.
3. The Help Desk will provide an ID number for adjudication.

Finding a Network Pharmacy

Use one of these easy methods to find a network pharmacy:

- Visit your local **Walgreens** or **Rite Aid** Pharmacy
- Call us: **866.599.5426**
- Use our pharmacy locator online: **www.pmsionline.com/pharmacy-center**.

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