New Loss Required Reporting Documents

- **C-2 Form-** Employer's statement of accident.
- **C-11 Form-** Change in work status indicating the return to work date. Please note the C-11 is need only if the claimant has returned to work unless otherwise specified.
- **Police Report-** Necessary for identifying vehicle and driver involved in accident.
- **MV-104-** The claimant's statement regarding the accident.
- **Hack License & Drivers License-** Necessary for identifying the claimant.
- **Dispatch Log-** Record of indicating the driver was on a dispatch call.

Please Mail Documents To:

Hereford Insurance Co.

36-01 43rd Ave.

Long Island City, NY 11101

OR Fax to: **(718) 937-5918**

Claims should be sent to the attention of:

Susana Rojas or Justine Young

Worker's Compensation In –Take Unit

(718) 361-9191 Ext. 7115 or 7160

srojas@herefordinsurance.com

jyoung@herefordinsurance.com

EMPLOYER'S REPORT OF WORK-RELATED INJURY/ILLNESS C-2

State of New York - Workers' Compensation Board

If one of your employees has a work-related injury or illness, you must complete and file this form **within 10 days** of the injury/illness or be subject to a penalty. For additional information on filing this form please refer to Workers' Compensation Law Section 110 at the end of this form. Type or print neatly.

WCB Case Number (if you know it): _____ Date of Injury/illness: ____/____/____

Carrier Case Number (if you know it): _____ Date of this Report: ____/____/____

A. EMPLOYER INFORMATION

1. Employer: _____ 2. Employer FEIN: _____

3. Mailing Address: _____

4. Location Address (if different): _____

5. Phone Number: (____)_____ 6. Nature of Business or Industry Code: _____

7. OSHA Case Number (if known): _____ 8. NY UI Employer Reg Number: _____

B. INSURANCE CARRIER / SELF-INSURED EMPLOYER

If individually self-insured, enter your Board W Number and skip to Section C.

1.Board W Number: **W** _____ 2. Carrier/Group Name: _____

3. Policy Number: _____ Policy Period: From: ____/____/____ To: ____/____/____

4. If Carrier Unknown, Insurance Agent Name: _____ 5. Phone Number: (____)_____

C. EMPLOYEE'S PERSONAL INFORMATION

1. Name: _____ 2. Date of Birth: ____/____/____
First MI Last

3. Mailing Address: _____

4. Social Security Number: _____ 5. Contact Phone Number:(____)_____ 6. Gender: ☐ Male ☐ Female

D. EMPLOYEE'S INJURY OR ILLNESS

1. Time of day employee began work on date of injury: _____ ☐ AM ☐ PM 2. Time of injury: _____ ☐ AM ☐ PM

3. Has the employee given you notice of injury/illness? ☐ Yes ☐ No

If yes, notice was given to: _____ ☐ orally ☐ in writing Date notice provided: ____/____/____

If available, attach a copy of the employee's written notice and medical notes, and the employer's incident report.

4. Have you given the employee a Claimant Information Packet? ☐ Yes ☐ No If yes, give date: ____/____/____

5. Where did the injury/illness happen (e.g., 1 Main St., Pottersville, at the front door): _____

_____

6. Was this location where the employee normally worked? ☐ Yes ☐ No If no, why was the employee there? _____

_____

7. Employee's supervisor: _____ 8. Did supervisor see injury happen? ☐ Yes ☐ No ☐ Unknown

9. Did anyone else see the injury happen? ☐ Yes ☐ No ☐ Unknown If yes, give name(s): _____

_____

10. What was the employee doing when he/she was injured or became ill? (e.g., unloading a truck, stocking a shelf, typing annual report)

_____

_____

EMPLOYEE'S NAME: _____ DATE OF INJURY/ILLNESS: ____/____/____
First MI Last

D. EMPLOYEE'S INJURY OR ILLNESS *continued*

11. How did the injury/illness occur? (e.g., the employee tripped over a pipe and fell on the floor) _____

12. Explain fully the nature of the employee's injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

13. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what was it? _____

14. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No

If yes, ☐ employee's vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): _____

If employer's vehicle was involved, give name and address of your motor vehicle insurance carrier: _____

15. Did the injury/illness result in the employee's death? ☐ Yes ☐ No If yes, what was the date of death? ____/____/____

Name and address of the nearest relative: _____

E. MEDICAL TREATMENT

1. What was the date of the employee's first treatment? ____/____/____ ☐ None received ☐ Unknown

2. Where did the employee receive first medical treatment for this injury/illness? ☐ On site ☐ Doctor's office ☐ Emergency Room ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours ☐ Unknown

Who treated the employee and where? _____

3. Is the employee still being treated for this injury/illness? ☐ Yes ☐ No ☐ Unknown If yes, name and address of treating doctor(s):

4. To your knowledge, did the employee have another work-related injury to the same body part or a similar illness while working for you?

☐ Yes ☐ No If yes, name the doctor(s) who treated the previous injuries/illnesses (if known): _____

F. RETURN TO WORK

1. Did the employee stop work because of his/her injury/illness? ☐ Yes ☐ No If yes, on what date? ____/____/____

2. Has the employee returned to work? ☐ Yes ☐ No

If yes, on what date? ____/____/____ ☐ regular duty ☐ limited duty

3. If the employee has returned to limited duty, what are his/her average gross earnings per week? _____

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

EMPLOYER'S REPORT OF INJURED EMPLOYEE'S CHANGE IN EMPLOYMENT STATUS RESULTING FROM INJURY

This report is to be filed directly with the Chair, Workers' Compensation Board at the address shown on reverse side as soon as the employment status of an injured employee, as reported on Form C-2 or EC-2, or on a previous Form C-11 or EC-11, is changed. Change in employment status includes return to work, discontinuance of work, increase or decrease of regular hours of work and increase or reduction of wages. **A copy should also be sent to your insurance carrier.**

ALL COMMUNICATIONS SHOULD REFER TO THESE NUMBERS		3. Carrier Code	4. Date of Injury	5. Claimant's Soc. Sec. No.
1. W.C.B. Case Number	2. Carrier Case Number			

	Name	Address to which notice should be sent (Give Number and Street, City, State, and Zip Code)	
6. Injured Person			Apt.No.
7. Employer			
8. Carrier			

9. Date of most recent Employer's Report filed: (check "x" & give date filed) ☐ C-2/EC-2_____ ☐ C-11/EC-11_____

10. Date of first full day employee lost from work: _____ 11. Nature of Injury:_____

_____

_____

12. Date employee returned to work: _____

13. (a) Change of employment status resulting from above injury:

Employment Status	Hours per Day	Days per Week	Earnings	Occupation
Prior To Injury				
Changed To				

(b) Date of this change in employment status:_____ (c) Remarks:_____

_____

14. Loss of time resulting from above injury since first return to work:

From (Mo., Day, Year)	TO (Mo., Day, Year)	Reason

15. Is injured person still under physician's care?_____ If yes, give name of physician:_____

16. Has injured person died?_____ If yes, give date of death:_____

Name and address of nearest known relative:_____

Date of this Report_____ Tel. No._____Firm Name_____

Prepared By:_____ Official Title_____

MV-104 (7/05) **PAGE 1 of 2**

FOLD → ← HERE

Use only for accidents that happen in New York State

New York State Department of Motor Vehicles

REPORT OF MOTOR VEHICLE ACCIDENT

www.nysdmv.com

BEFORE COMPLETING THIS FORM, READ THE INSTRUCTIONS IN SECTION A ON PAGE 2

DO NOT FORGET ACCIDENT DATE ↓ Page _____ of _____ ☐ ***RUSH*** - **DRIVER OF VEHICLE 1 - LICENSE SUSPENDED FOR FAILURE TO REPORT**

Accident Date Month / Day / Year	Day of Week	Time ☐ AM ☐ PM	Number of Vehicles	Number Injured	Number Killed	Did police investigate accident at scene? ☐ Yes ☐ No	If "Yes", Name of Police Agency or Precinct & Accident Number

DRIVER

DRIVER OF VEHICLE 1	☐ VEHICLE 2 ☐ PEDESTRIAN ☐ BICYCLIST ☐ OTHER PEDESTRIAN
❶ Driver License ID Number / State of License	Driver License ID Number / State of License
Driver Name–exactly as printed on license (Last, First, M.I.)	Name–exactly as printed on license (Last, First, M.I.)
Address (*Include Number & Street*) / Apt. Number	Address (*Include Number & Street*) / Apt. Number
City or Town / State / Zip Code	City or Town / State / Zip Code
Date of Birth Month / Day / Year; Sex; Number of People in Vehicle; Public Property Damaged ☐	Date of Birth Month / Day / Year; Sex; Number of People in Vehicle; Public Property Damaged ☐

REGISTRANT

❷	
Name–exactly as printed on registration; Date of Birth Month / Day / Year; Sex	Name–exactly as printed on registration; Date of Birth Month / Day / Year; Sex
Address (*Include Number & Street*) / Apt. Number	Address (*Include Number & Street*) / Apt. Number
City or Town / State / Zip Code	City or Town / State / Zip Code
Plate Number; State of Reg.; Vehicle Year & Make; Vehicle Type; Ins. Code	Plate Number; State of Reg.; Vehicle Year & Make; Vehicle Type; Ins. Code

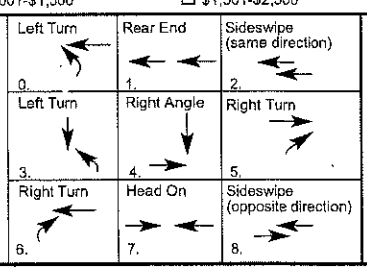
VEHICLE DAMAGE

❸ Estimated Cost of Property Damage - Vehicle 1: ☐ $1,001-$1,500 ☐ $1,501-$2,500 ☐ Over $2,500

Estimated Cost of Property Damage - Vehicle 2: ☐ $1,001-$1,500 ☐ $1,501-$2,500 ☐ Over $2,500

Describe damage to vehicle 1

ACCIDENT DIAGRAM: Circle one of the 9 diagrams (numbered 0-8) if it describes the accident, or draw your own diagram below in space #9. Number the vehicles. Your vehicle is # 1



Describe damage to vehicle 2

9.

ACCIDENT LOCATION

❹ **Place Where Accident Occurred in New York State:**

County _____ ☐ City ☐ Village ☐ Town of _____. Permanent Landmark _____

Road on which accident occurred _____ (Route Number or Street Name)

at ☐ 1) intersecting street _____ (Route Number or Street Name)

or 2) _____ Feet _____ Miles ☐N ☐S ☐E ☐W of _____ (Milepost, Nearest intersecting Route Number or Street Name)

How did the accident happen?

ALL INVOLVED

❺

Names of All Persons Involved	8. Which Veh. Occupied	9. Position in/on Vehicle	10. Safety Equip.Used	12. Age	13. Sex	16. Injury A	B	C	Describe Injuries	If Deceased, Enter Date of Death

INSURANCE

❻

Identify Damaged Property Other Than Vehicle(s)	VIN
Name of Insurance Company That Issued Policy For Vehicle 1	Policy Number
Name and Address of Policy Holder	Policy Period From To
If Vehicle was Operated Under Permit (ICC, USDOT or NYSDOT), give No.	Name and Address of Permit Holder
If Self-Insured, give Certificate No.	and State

Date	Print Name of Driver *(or Representative*)* of Vehicle 1	Signature of Driver *(or Representative*)* of Vehicle 1 ➧

* A representative may sign for the driver if the driver is unable to sign because of injury or death. If you are signing as the driver's representative, check the box that describes why the driver cannot sign. ☐ Injury ☐ Death

An accident report is not considered complete and filed unless it is signed, and if not signed may result in the suspension of your driver's license.

1 2 3 4 5 6 7 23 24 25 26 27 28 29 30

SIGNED STATEMENT QUESTIONAIRE

Workers' Compensation Claims Dept

Insured/Base – Livery Fund Driver

- Copy TLC / Driver's Licenses, Police report, MV104, Dispatch Log
- Place date, address and page number at top of statement form
- **Start statement in 1st person (I, John Doe).**

Insured Information:

- I , title (owner, base dispatcher).

- Date of birth, soc security#, address, work/home/cell telephone#.

- **Base name, number, location.**

- Date/time of accident/incident.

- Type of accident/incident (MVA, crime/assault).

- **Car number.**
- **Base Dispatched call, private or street pick up?**

- **Time Base dispatched.**
- **Dispatched address/location.**
-
- **Passenger(s)? Number? Sex, position seated in cab.**

- **If yes, time picked up? Drop off?**
- **Drop off address/location (or) accident location.**

- **If crime: Type of incident. Committed by? Number of assailants, sex?**

- Police at scene. Report taken. Were tickets/summons issued. Arrest made.

- Any alcohol/drug/medication influence.
- Witnesses to accident.

Verify Claimant Information with Base: (if not on C2).

- Telephone numbers (home/cell).

- Occupation. Full or part time worker. Shift/hours works.
- Social Security number.
- Hack license/drivers license#, expiration dates (if copy not received).
- Regular shift/days worked. Full or part time.
- Taxi/vehicle - Registered owner. Rent/Lease.

- Who responsible for vehicle maintenance and repairs.

- RTW / date (or) not working, date.
- Trip / dispatched log (request).
- Prior subsequent accidents? Dates.

Medical Treatment (emergency & follow up care):

- Ambulance/EMS to hospital. Name of hospital.
- **Type of Injuries.**
- Treating Dr. name/address/telephone#/specialty.
- Prior injuries/medical condition(s).

Attorney:

- Name/address/Telephone number.

Other:

Any person who knowingly and with intent to defraud any Insurance company or files a statement of claim containing materially false information, commits a fraudulent insurance act, is a crime.

Hereford Employee Name	HIC Employee Signature	Date
Name (print)	Signature	Date
Notary Stamp	Notary Signature	Date