STATE OF NEW YORK

WORKERS' COMPENSATION BOARD

PROOF OF BURIAL AND FUNERAL EXPENSES-BY UNDERTAKER

W. C. B. Case No. **Carrier Case No.** **Social Security No.**

STATE OF NEW YORK ....
COUNTY OF.. } **SS.:**

....being duly sworn, says, that (s)he is a duly licensed undertaker of ....at...
(city or town) (street and number)

that on the ....day of............................,...........,(s)he prepared the body of ....

.... for burial; that (s)he placed a coffin, containing the said body in a ....
(grave, vault, express car)

in ....cemetery; that (s)he shipped said body via ....

to .... at ....
(relative, friend, etc.)

that (s)he was directed to conduct such burial by ....
(name)

.... who authorized the following itemized bill:
(address)

....	$.....................
....	....
....	....
....	....
....	....
....	....
....	....
....	....
....	....
Total	$

That (s)he was informed said bill would be paid by ....
(name)

...., that no part of said bill of expenses so
(address)

authorized for said burial has been paid, except,

$ .... by ....
(name) (address)

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

(Signed) ....

Subscribed and sworn to before me, this .... day of ...., ...

....
Notary Public

State of New York - Workers' Compensation Board

CLAIM FOR VOLUNTEER AMBULANCE WORKERS' BENEFITS IN A DEATH CASE

This claim will be processed more quickly if copies of necessary documents are submitted to the Board. Attach copies of the documents which you have in your possession. Otherwise obtain copies and bring them to the first hearing. DO NOT DELAY filing this claim form. Necessary documents are as follows:

a. A medical report from doctor who treated the deceased.
b. Death certificate.
c. Proof of relationship such as birth certificate, marriage certificate, adoption papers, etc.
d. Itemized funeral bill.

Does this claim involve disease or malfunction of the heart or of one or more coronary arteries? ☐ Yes ☐ No

W.C.B. CASE NO.(if known)	CARRIER CASE NO.	CARRIER CODE NO.	DECEDENT'S SOC. SEC. NO.	CLAIMANT'S SOC. SEC. NO.	DATE OF ACCIDENT

	NAME	ADDRESS (Give No, Street,City, State and Zip Code)	Apt. No.
DECEASED VOLUNTEER AMB. WORKER			
AMBULANCE COMPANY			
POLITICAL SUBDIVISION LIABLE FOR			
CARRIER			
CLAIMANT			Apt. No.

I hereby make claim for death benefits payable under the Volunteer Ambulance Workers' Benefit Law for injury to the deceased volunteer ambulance worker named above sustained in the line of duty and in support of this claim, I submit the following information:

1. a. Death occurred on (Date)____________ at (Place)____________ (Attach Death Certificate If Available)

   b. Date of injury ____________ at ______ o'clock ______ M.

   c. Address and community where injury occurred ____________

   d. Was volunteer ambulance worker injured in the line of duty in the jurisdiction of his/her ambluance district or political subdivision? ☐ Yes ☐ No

   If volunteer ambulance worker was injured in the line of duty involving an assistance call from another locality, give name of other ambulance district or political subdivision ____________

   e. Cause of injury (Describe fully what factors or events led up to or contributed to the injury.)____________

   f. Nature of injury and part of body injured____________

Note: Attach a medical report, if available.

	Name	Address
2. ATTENDING PHYSICIAN		
3. LAST PHYSICIAN OR HOSPITAL		
4. UNDERTAKER		
5. PERSON WHO PAID UNDERTAKER BILLS		

6. Amount of Undertaker's Bills $ __________ Amount paid, if any $__________ (Attach funeral bill, if available.)

7. Claimant's date of birth __________ 8. Relationship to deceased__________

9. Is deceased survived by a spouse and/or children under 18 years of age or under 25 years of age and enrolled and attending as full-time students in any accredited educational institution? ☐ Yes ☐ No

10. Survivors or dependents of the deceased - attach additional sheet if necessary (SEE INSTRUCTIONS ON REVERSE SIDE)

Name	Address	Birth Date	Relationship

NOTE: Attach proof of relationship such as birth certificate, marriage certificate, adoption papers, etc., if available.

IF YOU HAVE ANY QUESTIONS ABOUT CLAIMING DEATH BENEFITS, CONTACT THE NEAREST OFFICE OF THE WORKERS' COMPENSATION BOARD.

SI TIENE ALGUNAS PREGUNTAS RESPECTO A COMO RECLAMAR BENEFICIOS POR MUERTE, COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA DE COMPENSACION OBRERA.

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

11. IF YOU ARE THE SPOUSE OR CHILD OF THE DECEASED ENTER THE FOLLOWING INFORMATION AS APPLICABLE:

a. You were married to the deceased on (date) ______________________________ at (place)______________________________

by (person performing ceremony) ______________________________Attach marriage certificate if available.

b. Number of children under 18 years of age at the time of the death of the deceased. ________________

c. Number of children at least 18 years of age but under 25, enrolled and attending as full time students in any accredited educational institution at the time of the death of the deceased.________________

12. IF YOU ARE NEITHER THE SPOUSE OF THE DECEASED OR CHILD OF THE DECEASED UNDER 18 YEARS OF AGE OR UNDER 25 YEARS ENROLLED AND ATTENDING AS A FULL TIME STUDENT IN ANY ACCREDITED EDUCATIONAL INSTITUTION, ENTER THE FOLLOWING INFORMATION:

a. Were you wholly or partially dependent on the deceased for your support? ________________

b. If partially dependent, to what degree? ____________________

c. I own property as follows: (1) Real estate, assessed value $__________________________, from which I receive an income of $_________________ annually and on which there is an indebtedness of $ ______________________.

(2) What other sources of income do you have? (Name each source and give amounts derived from each source named.)

SOURCE AMOUNT

13. IF YOU ARE A CHILD OR DEPENDENT GRANDCHILD, DEPENDENT BROTHER OR DEPENDENT SISTER, AT LEAST 18 YEARS OF AGE BUT UNDER 25 AND ENROLLED AND ATTENDING AS A FULL TIME STUDENT IN ANY ACCREDITED EDUCATIONAL INSTITUTION, ENTER THE FOLLOWING INFORMATION AND ATTACH CERTIFICATION OF ATTENDANCE, IF AVAILABLE FROM SUCH INSTITUTION.

Name of Student	Name & Address of Educational Institution	Date Attendance Began

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

I certify that copy of this claim was filed with____
(Name of Officer)

______________________________ ______________________________on______________________________
(Title of Officer) (Political Subdivision Liable for Benefits)

Dated___________________________ Signed by______________________________ ______________________________ **or**
(Claimant's Signature) Telephone No.

Signed by______________________________ ______________________________ ______________________________
(A person on behalf of claimant) (Relationship) Telephone No.

TO THE CLAIMANT

1. This claim for Death Benefits (Form VAW-62) must be filed within two years after death with the Chairman, Workers' Compensation Board at address shown below, AND the designated officer to whom the notice of injury or death must be given as follows:

If the political subdivision liable for benefits is a	*Then deliver to*
a. County	a. Clerk of the Board of Supervisors
b. City	b. Comptroller or Chief Financial Officer
c. Town	c. Town Clerk
d. Village	d. Village Clerk
e. Ambulance District	e. Secretary

The home county, city, town, village, or ambulance district is liable for the payment of benefits for injuries, regardless of whether service was rendered for the home area, or for another area under contract or in response to a call for assistance.

2. If the deceased's ambulance service was not affiliated with a political subdivision, file this form with the head of the unaffiliated ambulance service.
3. Under the Volunteer Ambulance Workers' Benefits Law, "persons" who may be eligible to claim death benefits include only the following:
   a. Widow or widower;
   b. Children who were under the age of 18 at the time of death;
   c. Children of any age who were totally blind or physically disabled at the time of injury and whose disablement is total and permanent;
   d. Grandchildren and brothers and sisters of the deceased who were under the age of 18 at the time of death and wholly or partially dependent upon the deceased for support at the time of injury;
   e. Parents and grandparents of the deceased who were wholly or partially dependent upon the deceased for support at the time of injury;
   f. Effective July 1, 1976, children and dependent grandchildren, dependent brothers and dependent sisters under 25 years of age who are enrolled as full time students in any accredited educational institution.
4. Each claimant must file a separate claim except that only one claim need be filed by a spouse and/or children of the deceased under age 18 or under 25 and enrolled as full time students in any accredited educational institution.
5. Section 40 of the Volunteer Ambulance Workers' Benefit Law requires that unless a claim for death benefits has been filed WITHIN NINETY DAYS after death, a written notice of death shall be given to the designated officer of the political subdivision or unaffiliated volunteer ambulance service liable for benefits by personal delivery or by registered mail within said ninety day period. Form VAW-1 has been prescribed for this purpose. Form VAW-1 is not a claim for death benefits. Form VAW-62, Claim for Death Benefits, if filed within ninety days after death, serves also as Notice of Death in place of Form VAW-1.

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. Sec. 552a).

The Workers' Compensation Board's ("Board") authority to request personal information from claimants is derived from Sections 20 and 142 of the Workers' Compensation Law. This information is collected to assist the Board in processing claims in an efficient manner and to help it maintain accurate claim records.

The Board is strongly committed to protecting the confidentiality of all personal information that it collects. Such information will be disclosed within the agency only to Board personnel and agents in furtherance of their official duties. Personal information will be disclosed outside the agency only in accordance with applicable state and federal law.

The Board's Director of Operations, located at 100 Broadway, Menands, New York 12241 (518-474-6674), is primarily responsible for the maintenance of agency records containing personal claimant information.

Failure to provide the information requested on this form will not result in the denial of your claim, but may delay the processing of your claim. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your claim.

Claims should be sent to the district office of the Workers' Compensation Board at one of these addresses:

ALBANY 12241 - 100 Broadway, Menands. (866) 750-5157 For all accidents in following counties: Albany, Clinton, Columbia, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Ulster, Warren, Washington.

BINGHAMTON 13901 - State Office Building, 44 Hawley Street. (866) 802-3604 For all accidents in following counties: Broome, Chemung, Chenango, Cortland, Delaware, Otsego, Schuyler, Sullivan, Tioga, Tompkins.

BUFFALO 14202 - Statler Towers, 107 Delaware Ave. (866) 211-0645 For all accidents in following counties: Cattaraugus, Chautauqua, Erie, Niagara.

ROCHESTER 14614 - 130 Main Street West. (866) 211-0644 For all accidents in following counties: Allegany, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming, Yates.

SYRACUSE 13203 - 935 James Street. (866) 802-3730 For all accidents in following counties: Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence.

DOWNSTATE CENTRALIZED MAILING (for New York City, Hempstead, Hauppauge & Peekskill district offices) - PO Box 5205, Binghamotn, NY 13902-5205. NYC (800) 877-1373 Hemp. (866) 805-3530 Haup. (866) 681-5354 Peek. (866) 746-0552 For all accidents in following counties: Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Westchester.

State of New York - Workers' Compensation Board

CLAIM FOR VOLUNTEER FIREFIGHTERS' BENEFITS IN A DEATH CASE

This claim will be processed more quickly if copies of necessary documents are submitted to the Board. Attach copies of the documents which you have in your possession. Otherwise obtain copies and bring them to the first hearing. DO NOT DELAY filing this claim form. Necessary documents are as follows:

- **a. A medical report from doctor who treated the deceased.**
- **b. Death certificate.**
- **c. Proof of relationship such as birth certificate, marriage certificate, adoption papers, etc.**
- **d. Itemized funeral bill.**

Does this claim involve disease or malfunction of the heart or of one or more coronary arteries? ☐ Yes ☐ No

W.C.B. CASE NO.(if known)	CARRIER CASE NO.	CARRIER CODE NO.	DECEDENT'S SOC. SEC. NO.	CLAIMANT'S SOC. SEC. NO.	DATE OF ACCIDENT

	NAME	ADDRESS (Give No, Street,City, State and Zip Code)	Apt. No.
DECEASED VOLUNTEER FIREFIGHTER			
FIRE COMPANY			
POLITICAL SUBDIVISION LIABLE FOR BENEFITS			
CARRIER			
CLAIMANT			Apt. No.

I hereby make claim for death benefits payable under the Volunteer Firefighters' Benefit Law for injury to the deceased volunteer firefighter named above sustained in the line of duty and in support of this claim, I submit the following information:

1. a. Death occurred on (Date)______________________at (Place)____

   b. Date of injury _________________________at_________o'clock__________M. (Attach Death Certificate If Available)

   c. Address and community where injury occurred ____

   d. Was volunteer firefighter injured in the line of duty in the jurisdiction of his/her fire district or political subdivision? ☐ Yes ☐ No

   If volunteer firefighter was injured in the line of duty involving an assistance call from another locality, give name of other fire district or political subdivision ____

   e. Cause of injury (Describe fully what factors or events led up to or contributed to the injury.)____

   ____

   f. Nature of injury and part of body injured____

Note: Attach a medical report, if available.

	Name	Address
2. ATTENDING PHYSICIAN		
3. LAST PHYSICIAN OR HOSPITAL		
4. UNDERTAKER		
5. PERSON WHO PAID UNDERTAKER BILLS		

6. Amount of Undertaker's Bills $ ____________________ Amount paid, if any $______________________ (Attach funeral bill, if available.)
7. Claimant's date of birth ______________________ 8. Relationship to deceased__________________________________
9. Is deceased survived by a spouse and/or children under 18 years of age or under 25 years of age and enrolled and attending as full-time students in any accredited educational institution? ☐ Yes ☐ No

10. Survivors or dependents of the deceased - attach additional sheet if necessary (SEE INSTRUCTIONS ON REVERSE SIDE)

Name	Address	Birth Date	Relationship

NOTE: Attach proof of relationship such as birth certificate, marriage certificate, adoption papers, etc., if available.

IF YOU HAVE ANY QUESTIONS ABOUT CLAIMING DEATH BENEFITS, CONTACT THE NEAREST OFFICE OF THE WORKERS' COMPENSATION BOARD.

SI TIENE ALGUNAS PREGUNTAS RESPECTO A COMO RECLAMAR BENEFICIOS POR MUERTE, COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA DE COMPENSACION OBRERA.

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

11. IF YOU ARE THE SPOUSE OR CHILD OF THE DECEASED ENTER THE FOLLOWING INFORMATION AS APPLICABLE:

a. You were married to the deceased on (date) ______________________ at (place)______________________
by (person performing ceremony) ______________________Attach marriage certificate if available.

b. Number of children under 18 years of age at the time of the death of the deceased. ____________

c. Number of children at least 18 years of age but under 25, enrolled and attending as full time students in any accredited educational institution at the time of the death of the deceased.____________

12. IF YOU ARE NEITHER THE SPOUSE OF THE DECEASED OR CHILD OF THE DECEASED UNDER 18 YEARS OF AGE OR UNDER 25 YEARS ENROLLED AND ATTENDING AS A FULL TIME STUDENT IN ANY ACCREDITED EDUCATIONAL INSTITUTION, ENTER THE FOLLOWING INFORMATION:

a. Were you wholly or partially dependent on the deceased for your support? ____________

b. If partially dependent, to what degree? ____________

c. I own property as follows: 1) Real estate, assessed value $____________, from which I receive an income of $____________ annually and on which there is an indebtedness of $ ____________

(2) What other sources of income do you have? (Name each source and give amounts derived from each source named.)

SOURCE	AMOUNT

13. IF YOU ARE A CHILD OR DEPENDENT GRANDCHILD, DEPENDENT BROTHER OR DEPENDENT SISTER, AT LEAST 18 YEARS OF AGE BUT UNDER 25 AND ENROLLED AND ATTENDING AS A FULL TIME STUDENT IN ANY ACCREDITED EDUCATIONAL INSTITUTION, ENTER THE FOLLOWING INFORMATION AND ATTACH CERTIFICATION OF ATTENDANCE, IF AVAILABLE FROM SUCH INSTITUTION.

Name of Student	Name & Address of Educational Institution	Date Attendance Began

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

I certify that copy of this claim was filed with______________________
(Name of Officer)

____________ (Title of Officer) ____________ (Political Subdivision Liable for Benefits) on____________

Dated____________ Signed by____________ (Claimant's Signature) ____________ (Telephone No.) **or**

Signed by____________ (A person on behalf of claimant) ____________ (Relationship) ____________ (Telephone No.)

TO THE CLAIMANT

1. This claim for Death Benefits (Form VF-62) must be filed within two years after death with the Chairman, Workers' Compensation Board at address shown below, AND the designated officer to whom the notice of injury or death must be given as follows:

If the political subdivision liable for benefits is a	*Then deliver to*
a. County	a. Clerk of the Board of Supervisors
b. City	b. Comptroller or Chief Financial Officer
c. Town	c. Town Clerk
d. Village	d. Village Clerk
e. Fire District	e. Secretary

The home county, city, town, village, or fire district is liable for the payment of benefits for injuries, regardless of whether service was rendered for the home area, or for another area under contract or in response to a call for assistance.

2. Under the Volunteer Firefighters' Benefits Law, "persons" who may be eligible to claim death benefits include only the following:
   a. Widow or widower;
   b. Children who were under the age of 18 at the time of death;
   c. Children of any age who were totally blind or physically disabled at the time of injury and whose disablement is total and permanent;
   d. Grandchildren and brothers and sisters of the deceased who were under the age of 18 at the time of death and wholly or partially dependent upon the deceased for support at the time of injury;
   e. Parents and grandparents of the deceased who were wholly or partially dependent upon the deceased for support at the time of injury;
   f. Effective July 1, 1976, children and dependent grandchildren, dependent brothers and dependent sisters under 25 years of age who are enrolled as full time students in any accredited educational institution.
3. Each claimant must file a separate claim except that only one claim need be filed by a spouse and/or children of the deceased under age 18 or under 25 and enrolled as full time students in any accredited educational institution.
4. Section 40 of the Volunteer Firefighters' Benefit Law requires that unless a claim for death benefits has been filed WITHIN NINETY DAYS after death, a written notice of death shall be given to the designated officer of the political subdivision liable for benefits by personal delivery or by registered mail within said ninety day period. Form VF-1 has been prescribed for this purpose. Form VF-1 is not a claim for death benefits. Form VF-62, Claim for Death Benefits, if filed within ninety days after death, serves also as Notice of Death in place of Form VF-1.

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. Sec. 552a).

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The Board's Director of Operations, located at 100 Broadway, Menands, New York 12241 (518-474-6674), is primarily responsible for the maintenance of agency records containing personal claimant information.

Failure to provide the information requested on this form will not result in the denial of your claim, but may delay the processing of your claim. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your claim.

Claims should be sent to the district office of the Workers' Compensation Board at one of these addresses:

ALBANY 12241 - 100 Broadway, Menands. (866) 750-5157 For all accidents in following counties: Albany, Clinton, Columbia, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Ulster, Warren, Washington.

BINGHAMTON 13901 - State Office Building, 44 Hawley Street. (866) 802-3604 For all accidents in following counties: Broome, Chemung, Chenango, Cortland, Delaware, Otsego, Schuyler, Sullivan, Tioga, Tompkins.

BUFFALO 14202 - Statler Towers, 107 Delaware Ave. (866) 211-0645 For all accidents in following counties: Cattaraugus, Chautauqua, Erie, Niagara.

ROCHESTER 14614 - 130 Main Street West. (866) 211-0644 For all accidents in following counties: Allegany, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming, Yates.

SYRACUSE 13203 - 935 James Street. (866) 802-3730 For all accidents in following counties: Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence.

DOWNSTATE CENTRALIZED MAILING (for New York City, Hempstead, Hauppauge & Peekskill district offices) - PO Box 5205, Binghamton, NY 13902-5205. NYC (800) 877-1373 Hemp. (866) 805-3630 Haup. (866) 681-5354 Peek. (866) 746-0552 For all accidents in following counties: Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Westchester.

STATE OF NEW YORK

WORKERS' COMPENSATION BOARD

THIIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

NOTICE TO LIABLE POLITICAL SUBDIVISION OF VOLUNTEER FIREFIGHTER'S INJURY OR DEATH

THIS NOTICE IS REQUIRED TO BE FILED WITHIN 90 DAYS AFTER THE DATE OF INJURY OR DEATH UNLESS CLAIM FOR BENEFITS, INCLUDING MEDICAL, HOSPITAL OR OTHER CARE, (VF-3 or VF-62) IS FILED WITHIN 90 DAYS AFTER THE DATE OF INJURY OR DEATH.

Sec.40 of the Volunteer Firefighters' Benefit Law provides that, unless Claim for Benefits is filed within 90 days after injury or death, Notice of such injury or death shall be given by delivery in person or by registered mail within 90 days by the injured volunteer firefighter or by any person claiming to be entitled to benefits, or by someone in his/her behalf, to the designated officer of the liable political subdivision as follows:

If the political subdivision liable for benefits is a	Then give to
a. County	a. Clerk of the Board of Supervisors
b. City	b. Comptroller or Chief Financial Officer
c. Town	c. Town Clerk
d. Village	d. Village Clerk
e. Fire District	e. Secretary

If your injury occured prior to March 1, 1964, the injury should be reported to the county, city, town, village or fire district for which the service was rendered whether such service was rendered for the home area or for another area under contract or in response to a call for assistance. If the injury occured on March 1, 1964 or thereafter, the home county, city, town, village or fire district is liable for thr payment of benefits regardless of whether the injury was incurred while serving your home area or an aided area. If you have any doubt concerning the liable political subdivision, a copy of this notice should be filed with all the political subdivisions involved.

THIS NOTICE IS NOT A CLAIM FOR BENEFITS. FAILURE TO FILE THE CLAIM FOR BENEFITS (FORM VF-3 or VF-62) WITHIN TWO YEARS AFTER INJURY OR DEATH MAY BAR YOU FROM RECEIVING BENEFITS.

To: ____

Name of Officer — Title of Officer — Political Subdivision Liable for Benefits

	First Name / Middle Initial / Last Name	Home Address / Apt. No.
1. VOLUNTEER FIREFIGHTER		
	Name	Address
2. FIRE COMPANY		
3. POLITICAL SUBDIVISION OR FIRE DISTRICT		
4. REGULAR EMPLOYER, IF ANY		

5. Address and community where injury occurred________________________________

____

6. (a) Date of injury__________________ at_____o'clock____M. (b) Date of death__________________

(c) Place of death____

7. State fully nature and cause of injury or death______________________________

____

____

Dated______________________ Signed by______________________________, or

Volunteer Firefighter

Signed by____

A person on his/her behalf, or in case of death, by any one or more of his/her dependents, or by a person on their behalf. — Relationship

STATE OF NEW YORK

WORKERS' COMPENSATION BOARD

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

NOTICE TO LIABLE POLITICAL SUBDIVISION OR UNAFFILIATED AMBULANCE SERVICE OF VOLUNTEER AMBULANCE WORKER'S INJURY OR DEATH

THIS NOTICE IS REQUIRED TO BE FILED WITHIN 90 DAYS AFTER THE DATE OF INJURY OR DEATH UNLESS CLAIM FOR BENEFITS, INCLUDING MEDICAL, HOSPITAL OR OTHER CARE, (VAW-3 or VAW-62) IS FILED WITHIN 90 DAYS AFTER THE DATE OF INJURY OR DEATH.

Sec. 40 of the Volunteer Ambulance Workers' Benefit Law provides that, unless claim for benefits is filed within 90 days after injury or death, notice of such injury or death shall be given by delivery in person or by registered mail within 90 days by the injured volunteer ambulance worker or by any person claiming to be entitled to benefits, or by someone in his/her behalf, to the designated officer of the liable political subdivision as follows:

If the political subdivision liable for benefits is a	Then give to
a. County	a. Clerk of the Board of Supervisors
b. City	b. Comptroller or Chief Financial Officer
c. Town	c. Town Clerk
d. Village	d. Village Clerk
e. Ambulance District	e. Secretary

If at the time of injury the volunteer ambulance worker was a member of a voluntary service which was not affiliated with a county, city, town, village or ambulance district, this notice is to be filed with the ambulance service in which he or she served. However, please note that such unaffiliated services are not required to have coverage under the Volunteer Ambulance Workers' Benefit Law.

THIS NOTICE IS NOT A CLAIM FOR BENEFITS. FAILURE TO FILE THE CLAIM FOR BENEFITS (FORM VAW-3 or VAW-62) WITHIN TWO YEARS AFTER INJURY OR DEATH MAY BAR YOU FROM RECEIVING BENEFITS.

To: ____

Name of Officer Title of Officer Political Subdivision Liable for Benefits

1. VOLUNTEER AMBULANCE WORKER	First Name Middle Initial Last Name	Home Address Apt. No.
2. AMBULANCE COMPANY	Name	Address
3. POLITICAL SUBDIVISION OR AMBULANCE DISTRICT, IF ANY		
4. REGULAR EMPLOYER, IF ANY		

5. Address where injury occurred____

____

6. (a) Date of injury___________________________ at_____o'clock____M. (b) Date of death_____________________________

(c) Place of death____

7. State fully nature and cause of injury or death____

____

____

Dated_______________________________ Signed by____,

Volunteer Ambulance Worker

Signed by____

A person on his/her behalf, or in case of death, by any one or more of his/her dependents, or by a person on their behalf. Relationship

VAW - 1 (8-97)

VAW-501 (1-06)

VOLUNTEER AMBULANCE WORKER BENEFIT RATES - DEATH BENEFITS

Date of death	Maximum aggregate weekly death benefits	Maximum aggregate funeral expenses	Lump sum to spouse or estate	Surviving spouse - no child	Surviving spouse and child					Surviving child or children - no surviving spouse	No Surviving Spouse or Child	
					Spouse	Child or children	To each child, upon death or remarriage of spouse		To spouse, after payments to children cease		Dependent grand-children, brothers and sisters	Dependent parent or grand-parent
							Remarriage	Death				
7-1-92 to PRESENT	$400 **Effective 7-27-04** $800 **Effective 1-2-06** $887	$3,000 **Effective 7-27-04** $6,000 **Effective 1-2-06** $6,700	$5,000 **Effective 7-27-04** $50,000 **Effective 1-2-06** $56,000	$400 per week; $41,600 upon remarriage **Effective 7-27-04** $800 per week; $83,200 upon remarriage **Effective 1-2-06** $887 per week; $92,219 upon remarriage	$220 per week; $22,880 upon remarriage **Effective 7-27-04** $440 per week; $45,760 upon remarriage **Effective 1-2-06** $488 per week; $50,720 upon remarriage	$180 per week, share and share alike **Effective 7-27-04** $360 per week, share and share alike **Effective 1-2-06** $400 per week, share and share alike	If 1 child, $180 per week; if 2 children, $150 per week to each; if 3 or more children, $400 per week, share and share alike **Effective 7-27-04** If 1 child, $360 per week; if 2 children, $300 per week; if 3 or more children, $800 per week, share and share alike **Effective 1-2-06** If 1 child, $400 per week; if 2 children, $333 per week; if 3 or more children, $887 per week, share and share alike	$400 per week, share and share alike **Effective 7-27-04** $800 per week, share and share alike **Effective 1-2-06** $877 per week, share and share alike	$400 per week; $41,600 upon re-marriage **Effective 7-27-04** $800 per week; $83,200 upon re-marriage **Effective 1-2-06** $887 per week; $92,219 upon re-marriage	$400 per week, share and share alike **Effective 7-27-04** $800 per week, share and share alike **Effective 1-2-06** $887 per week, share and share alike	$150 per week to each, subject to maximum aggregate **Effective 7-27-04** $300 per week to each, subject to maximum aggregate **Effective 1-2-06** $333 per week to each, subject to maximum aggregate	$240 per week to each, subject to maximum aggregate **Effective 7-27-04** $480 per week to each, subject to maximum aggregate **Effective 1-2-06** $532 per week to each, subject to maximum aggregate

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VOLUNTEER FIREFIGHTERS BENEFIT RATES - DEATH BENEFITS

Date of death	Maximum aggregate weekly death benefits	Maximum aggregate funeral expenses	Lump sum to spouse or estate	Surviving spouse - no child	Surviving spouse and child					Surviving child or children - no surviving spouse	No Surviving Spouse or Child	
					Spouse	Child or children	To each child, upon death or remarriage of spouse		To spouse, after payments to children cease		Dependent grand-children, brothers and sisters	Dependent parent or grand-parent
							Re-marriage	Death				
1-1-99 to PRESENT	$800 **Effective 1-2-06** $887	No maximum if death is a direct result of firefighting; otherwise, $6,000 **Effective 1-2-06** $6,700	$50,000 **Effective 1-2-06** $56,000	$800 per week; $83,200 upon re-marriage **Effective 1-2-06** $887 per week; $92,219 upon re-marriage	$440 per week; $45,760 upon remarriage **Effective 1-2-06** $488 per week; $50,720 upon remarriage	$360 per week, share and share alike **Effective 1-2-06** $400 per week, share and share alike	If 1 child, $360 per week; if 2 children, $300 per week to each; if 3 or more children, $800 per week, share and share alike **Effective 1-2-06** If 1 child, $400 per week; if 2 children, $333 per week to each; if 3 or more children, $887 per week, share and share alike	$800 per week, share and share alike **Effective 1-2-06** $887 per week, share and share alike	$800 per week; $83,200 upon re-marriage **Effective 1-2-06** $887 per week; $92,219 upon re-marriage	$800 per week, share and share alike **Effective 1-2-06** $887 per week, share and share alike	$300 per week to each, subject to maximum aggregate **Effective 1-2-06** $333 per week to each, subject to maximum aggregate	$480 per week to each, subject to maximum aggregate **Effective 1-2-06** $532 per week to each, subject to maximum aggregate