



# 1199SEIU National Benefit Fund For Home Care Employees

330 West 42nd Street, New York, N.Y. 10036

Dear Member:

The attached Accident or Occupational Disease Compensation Report must be filled out if you have been injured on the job or develop a work-related illness.

If you have suffered a job-related illness or injury, you are entitled to benefits under the WORKERS' COMPENSATION LAW, **not** from the union disability benefit plan.

**REMEMBER, UNDER WORKERS' COMPENSATION:**

- The maximum weekly benefit rate is **higher** and can continue indefinitely. You are not limited to 26 weeks of payments as in disability.
- If you use sick time, it can be restored.
- You can get cash settlements in addition to the weekly benefit for certain permanent injuries, whether you lose any time from work or not.

**TO PROTECT YOUR RIGHTS TO WORKERS' COMPENSATION BENEFITS, YOU MUST DO THE FOLLOWING:**

**STEP ONE: NOTIFY YOUR EMPLOYER AND THE BENEFIT FUND.**

You can notify your employer by giving a copy of this form to your supervisor after you have completed it.

You should mail the original (top sheet) only to the Benefit Fund in the addressed, postage-paid envelope. Be sure to keep the other two copies for yourself and the delegate.

After you have filed your claim, you should keep the Benefit Fund informed of developments in your case by sending copies of any forms you receive to the Fund.

**STEP TWO: GET MEDICAL CARE AS SOON AS POSSIBLE.**

Tell the doctor you were injured at work. **DO NOT** pay the doctor or hospital! Advise the doctor to send the report (pink C-4 form) and bills to your employer or its workers' compensation insurance carrier.

**STEP THREE: FILE A CLAIM FOR WORKERS' COMPENSATION (C-3) WITH THE WORKERS' COMPENSATION BOARD.**

This must be done **in addition to notifying your employer** in order to make sure that you get a hearing before the Workers' Compensation Board.

If you have any questions about your rights or have difficulty obtaining claim forms, or if you need assistance in filing your claim, workers' compensation attorneys, BRECHER FISHMAN PASTERNAK POPISH HELLER RUBIN & REIFF, P.C., are here at the fund's office on the 12th floor every Wednesday from 4:00 p.m. to 6:00 p.m. or at 1199's Long Island headquarters located at 50 Charles Lindbergh Blvd., 6th floor in Uniondale every second Wednesday of the month at 5:00 p.m.

You are welcome to come and see them at these times, or if that is not convenient, you may contact them directly at any of the following locations:

**BRECHER FISHMAN PASTERNAK POPISH HELLER RUBIN & REIFF, P.C.**

**New York City Office:**  
222 Broadway  
New York, NY 10038  
212-341-7900

**Brooklyn Office:**  
Brooklyn Renaissance Plaza  
335 Adams Street  
Brooklyn, NY 11201  
718-222-9800

**Staten Island Office:**  
136 Bay Street  
Staten Island, NY 10301  
718-222-9800

**Nassau County Office:**  
1325 Franklin Avenue  
Garden City, NY 11530  
516-742-3636

**Westchester County Office:**  
1 North Broadway  
White Plains, NY 10601  
914-328-8500

If you have questions or require assistance, you may call the Member Service Department of the National Benefit Fund at (646) 473-9200.



Benefit Fund Copy

1199SEIU NATIONAL BENEFIT FUND

(Please return in self-addressed envelope)

330 West 42nd Street New York, New York 10036

ACCIDENT OR OCCUPATIONAL DISEASE COMPENSATION REPORT (REPORTE DE ACCIDENTE O ENFERMEDAD OCUPACIONAL DE COMPENSACION)

- To be filled out and turned in or mailed to the National Benefit Fund Para ser llenado y devuelto o enviado por correo al National Benefit Fund

Name of Injured Employee / Nombre del Trabajador Accidentado Telephone No. / Numero de Telefono

Address / Direccion Social Security No. / Numero de Seguro Social

Employer / Empleador Department / Departamento Shift / Horario

Date of Injury / Dia del Accidente Division / Division Job Title / Titulo de Trabajo

Brief description of what happened: / Descripcion de lo que pasó:

Are you filing a Workers' Compensation claim as a result of this incident? / ¿Archiva usted un reclamo de la Compensación de Trabajadores como resultado de este incidente?

Could the injury have been prevented by a change in procedures used by the employer or worksite education and training? / ¿Pudiera haber sido prevenido el accidente si el empleador hubiera cambiado los procedimientos usados o si se hubiera empleado un programa educativo y de entrenamiento en el sito de trabajo?

If yes, what actions would you suggest that might prevent a similar incident occurring in the future? / ¿Der ser así, que acciones usted sugiera para prevenir que un incidente igual ocurriera en el futuro?

Delegate's name / Nombre del Delegado Department / Departamento Date form filled out / Fecha que se lleno el formulario Supervisor's Name