NYSIF® New York State Insurance Fund

CLAIM FOR REIMBURSEMENT OF WAGES PAID TO STATE EMPLOYEE

1. NYSIF Case Number	2. Date of Accident	3. WCB Case Number
Employee ID **N**	Name	Address and Zip Code
4. State Agency		
5. Employee		

6. Time Lost from Work

From	To (but not including)	Salary Received (Enter Exact Amount)			From	To (but not including)	Salary Received (Enter Exact Amount)		
Mo/Day/Yr	Mo/Day/Yr	Full	Half	Supplement	Mo/Day/Yr	Mo/Day/Yr	Full	Half	Supplement

7. Were any days of absence charged to employee's accrued leave credits? Yes ☐ No ☐

   If "Yes", indicate only those dates which have not been and will not be restored:

   _____

   If restoration of credits is withheld pending a decision by the Workers' Compensation Board, check this box: ☐

8. In the event this case is deemed compensable, the undersigned hereby claims reimbursement for wages paid during the period from _____ to _____. NYSIF shall seek full reimbursement for all wages paid during periods of compensable lost time, where permanency is awarded under Workers' Compensation Law Section 15(3)(a) through (t).

DATE: _____ SIGNED BY: _____

TELEPHONE NUMBER: _____ _____

This claim should be filed with the Chair of the Workers' Compensation Board before award of compensation is made. Copies of this form should also be sent to the employee, his or her representative and the New York State Insurance Fund.