

Claim for Benefits

Instructions: Please complete all sections thoroughly and mail original to:

Tompkins County Personnel Department (607)274-5526 (phone)
125 East Court Street
Ithaca, NY 14850 (607)274-5401 (fax)

1. **Claimant's Name:** _____
first last

2. **Claimant's Symptoms:** _____

3. **Medical Findings and Diagnosis:** _____

4. **Is surgery indicated?** **If yes, what kind of surgery?** **What date?**

Yes No _____ / _____ / _____

5. **Record of medical treatment:**

	Month	Day	Year
a. Date you first treated for this injury/illness and the related absence from work.			
b. Most recent treatment date			
c. Date claimant unable to perform regular duties because of this injury/illness			
d. Date claimant can perform regular duty			

- Is claimant able to perform light duty? Yes No If yes, when? _____ / _____ / _____
- Please suggest restrictions or accommodations of light duty (job description provided upon request): _____

- Is claimant able to work part-time? Yes No If yes, how many hours per week? _____ hrs/wk

6. **In your opinion, is the illness or injury arising out of and in the course of employment?** Yes No

If yes, have you filed a C4/C48 with our carrier EM Management at 111 Grant Ave. Endicott, New York 13760? Yes No

7. **Physician's name (please print):** _____

8. **Office address:** _____

9. **Physician's Signature:** _____ **Date:** _____ / _____ / _____

To be completed by Employee Only

Claim for Benefits

Instructions: Both sides of this claim form must be completed whenever a Tompkins County employee requests payment for absence due to illness or injury. Disability for personal illness or injury will be granted from the date the employee sees a physician, is deemed unable to work, and a completed claim form is submitted to Personnel by 9:00 AM, Monday following the end of the pay period in which disability is requested. A faxed copy will be accepted in an emergency, however, the original claim form must be received within five working days. Untimely receipt will void a claim for benefits. **Claim forms must be submitted for every pay period that disability is claimed.** In no instance will disability be granted for periods prior to a doctor's visit.

What is your affiliation (White Collar, Blue Collar, Corrections, Road/Civil or Management/Confidential):

1. Name: _____
first last

2. Date of birth: ___/___/___ Social Security Number: ___-___-___

3. Street address: _____
 City: _____ State: _____ Zip: _____

4. Phone number () _____ - _____

5. Job Title: _____ Department: _____

6. Date of Injury/Illness: ___/___/___ Nature of Illness/Injury (how, where and when did it occur): _____
 Date you became unable to work: ___/___/___ _____

7. Date you saw a doctor regarding this claim: ___/___/___ _____

8. Current Work Schedule:
 Shift/Hours: _____
 Regular Day(s) Off: _____

9. What benefits are you claiming? (check all that apply):

Wages, salary or disability

Damages for personal injury

Workers' compensation benefits

Unemployment Insurance Benefits

No fault automobile insurance benefits

10. Since your injury/illness have you worked for any other employer?

Yes No

If yes, please indicate date: ___/___/___

11. I hereby claim benefits and certify that for the period covered by this claim I was disabled, and that the foregoing statements, including any accompanying statements, are true and complete.

Signature: _____ Date: ___/___/___