

WARREN COUNTY SELF-INSURANCE PLAN
1340 STATE ROUTE 9
LAKE GEORGE NY 12845

EMPLOYER'S REQUEST FOR REIMBURSEMENT

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| WORKERS' COMPENSTATION BOARD CASE NO. _____ | WARREN COUNTY SELF-INSURANCE Carrier ID# W874754 Carrier Case No. _____ |
| CLAIMANT: _____ | |

RECEIPT FOR WAGES ADVANCED

Received from _____ employer,
_____ dollars and _____ cents (\$_____)

as wages during my absence from work on account of disability, which I allege resulted from accidental injury or occupational disease sustained by me on _____. These wages cover period from _____ to _____ (Incl.)

(date)

(Employee's Signature)

CLAIM FOR REIMBURSEMENT

To the Workers' Compensation Board:

In accordance with Section 25 of the Workers' Compensation Law, the undersigned employer, for wages paid during the above noted period of absence, hereby requests reimbursement at the compensation rate or in the event of a schedule loss, full amount of wages paid.

Date: _____

(Employer)

(Signature and Title)