# INSTRUCTIONS FOR COMPLETING RB-89.2

**TO THE APPLICANT**: An *Application for Reconsideration/Full Board Review*, *(Form RB-89.2)*, or hereafter "the application," must be filed within 30 calendar days after the notice of filing of the Memorandum of Board Panel Decision with the Secretary of the Board. *Form RB-89.2* is deemed filed with the Board on the date of actual receipt of such application by the Board. In accordance with 12 NYCRR 300.13(b)(3) and the Chair's designation, *Form RB-89.2* may only be filed with the centralized email address for claims (**wcbclaimsfiling@wcb.ny.gov**), or via the WCB Web Upload link (https://wcbdoc.services.conduent.com/). Unrepresented claimants may alternatively mail *Form RB-89.2* to the Board at the Board's centralized mailing address (PO Box 5205, Binghamton, NY 13902-5205). *RB-89.2* forms in workers' compensation discrimination claims must be filed with the Board by mailing the application to the Board's Discrimination Unit, PO Box 9029, Endicott, NY 13761-9029. *RB-89.2* forms in claims filed for disability benefits (claims for lost wages due to injuries or illnesses that are not work-related) must be filed with the Board by mailing the application to the Disability Benefits Bureau, PO Box 9029, Endicott, NY 13761-9029. A copy of this application must be served upon all necessary parties of interest in accordance with 12 NYCRR 300.13(b)(2)(iv). *Form RB-89.2*, unless submitted by an unrepresented claimant, must be in the format prescribed by the Chair and all sections of the application must be completed. Failure to supply all information required by 12 NYCRR 300.13 and these instructions may result in the application being denied.

> **NOTE**: *Applications for Reconsideration/Full Board Review* will not be accepted if hand delivered to a Board office. *RB-89.2* forms mailed or submitted directly to the Office of General Counsel will be deemed to have not been filed with the Board and will not be considered.

**TO ALL OTHER PARTIES**: Any *Rebuttal of Application for Reconsideration/Full Board Review (Form RB-89.3)* must be served on the Board within 30 calendar days following the date on which the application was served on the parties, as specified in the Proof of Service section of the *RB-89.2* form in accordance with 12 NYCRR 300.13(c).

**1. WCB Case Number(s).** Enter the WCB Case Number(s) of the claim(s) being appealed. WCB Case Number(s) includes the case number for workers' compensation, discrimination, disability benefits, paid family leave discrimination, volunteer firefighter, and volunteer ambulance worker benefits.

**2. Carrier Case Number(s).** Enter the Carrier Case Number(s) of the claim(s) being appealed. This section/item does not apply to claims for discrimination.

**3. Carrier Code.** Enter the Carrier Code of the carrier for the claim being appealed. This section/item does not apply to claims for discrimination.

**4. Carrier's Name.** Enter the name of the carrier for the claim being appealed. This section/item does not apply to claims for discrimination.

**5. Date of Injury/Leave.** Enter the date that the injury occurred, or the date paid family leave began (if paid family leave was not taken, enter the Discrimination Complaint Date).

**6. Claimant's Name.** Enter the complete name of the employee.

**7. Claimant's Address.** Enter the street address, city, state, and ZIP code of the employee, and mailing address if different.

**8. Party Requesting the Appeal.** Indicate which party is requesting the appeal/filing this *Application for Reconsideration/Full Board Review*.

**9. *Application for Reconsideration/Full Board Review*.** Indicate if the application is 1) Mandatory, or 2) Discretionary.

**10. Filing Date of the Memorandum of Board Panel Decision.** Enter the date of the decision that is being appealed.

**11. Remedy Sought.** Indicate the type of remedy being sought.

**12. Present Case Status.** Indicate the status of the case.

**13. Specify the Issue(s) for Review.** State the specific issue(s) for review.

**14. Basis of Appeal.** Provide a brief statement of the particular grounds upon which the appeal is based, including the specific findings of fact which are challenged and/or the errors of law which are alleged. General allegations which do not specifically bring to the attention of the Board the issues to be decided are insufficient. Additional sheets may be attached, up to a maximum of eight (8) pages.

**15. Hearing Dates, Transcripts, Documents, Exhibits, and Other Evidence.** Make reference to the record, or such part thereof, as is relevant to the issue(s) and ground(s) raised in this application. Indicate the hearing date(s) on which the issue(s) was raised before the Workers' Compensation Law judge (WCLJ), as well as any other relevant hearing dates. Identify by the date and/or document ID number(s), the transcripts, documents, reports, exhibits, and other evidence in the Board's file that are relevant to the issues and grounds being raised for review. If minutes are not transcribed, so indicate. Do not include with or attach to this application any documents that are present in the Board's file at the time the application is filed.

**16. Appeal to the Appellate Division of the Supreme Court, Third Department.** Indicate if an appeal of the Memorandum of Decision will be/has been taken to the Appellate Division of the Supreme Court, Third Department.

**17. Certification.** The preparer must sign and date the form (also providing their name, title, telephone number, and address) certifying to the application's good faith basis in law and fact, that it had been instituted with reasonable grounds, and had been served upon the necessary parties of interest in the Proof of Service section.

**18. Proof of Service.** The application must be served on all necessary parties of interest in accordance with 12 NYCRR 300.13(b)(2)(iv). Failure to properly serve a necessary party shall be deemed defective service and the application may be rejected by the Board. When the *Application for Board Review (Form RB-89)* is filed by the carrier, self-insured employer, or other payer or potential payer, service shall be upon the claimant, and claimant's legal representative, and other necessary parties of interest. Service is deemed timely if completed by the appellant within thirty (30) days of the filing of the decision by the Board. The affirmation must be completed and must include the method by which, and the date, the application was filed with the Board. The appellant shall only use one method to file the application with the Board. If the appellant files duplicate applications, such duplicate filings may be deemed to be raising or continuing an issue without reasonable grounds, and may subject the appellant to assessments under WCL § 114-a(3). The affirmation completed must specify the papers served, the names of the parties of interest served, the date and method of service for each party of interest, and that service was completed within 30 days from the filing of the decision that is the subject of the application. It is not acceptable to complete the portion of the affirmation where it lists those served and the method with “See attached.” If a party is served by email or other electronic means, the affirmation must include a certification that the party so served provided explicit permission to receive service by such means [see 12 NYCRR 300.13(b)(2)(iv)(C)]. The application does not have to be served on each party in the same manner. The affirmation must be dated and signed under penalty of perjury.

NEW YORK STATE Workers' Compensation Board

# APPLICATION FOR RECONSIDERATION / FULL BOARD REVIEW

PO Box 5205
Binghamton, NY 13902-5205

www.wcb.ny.gov

| 1. WCB Case Number(s) | 2. Carrier Case Number(s) | 3. Carrier Code | 4. Carrier's Name | 5. Date of Injury/Leave |
|---|---|---|---|---|
| | | | | |

| 6. Claimant's Name | 7. Claimant's Address |
|---|---|
| | |

**8. This application is made on behalf of:**

**9. This *Application for Reconsideration/Full Board Review* under WCL Sections 32 and 142(2) is:**

- ☐ Mandatory (there was a dissent other than the sole basis of which is referral to an impartial specialist)
- ☐ Discretionary

**10. Filing date of the Memorandum of Board Panel Decision** (mm/dd/yyyy)**:**

**11. The remedy sought is:**

- ☐ Administrative Correction of the Memorandum of Decision
- ☐ Modification of the Memorandum of Decision
- ☐ Reversal of the Memorandum of Decision
- ☐ Rescission of the Memorandum of Decision

**12. The case is presently (check one):** ☐ Disallowed ☐ Established

**13. State the specific issue(s) for review:**

**14. Basis of appeal.** This application for review is based on the following grounds (Additional sheets may be attached, up to a maximum of 8 pages):

**15. Hearing dates, transcripts, documents, exhibits, and other evidence.** (see instructions for details):

**16. Has or will an appeal of the Memorandum of Decision be taken to the Appellate Division of the Supreme Court, Third Department?**

☐ Yes ☐ No

**17. Certification:** By signing this document in the space provided below, I certify that this application has a good faith basis in law and fact, has been instituted with reasonable grounds, and has been served upon all necessary parties of interest using the method of service, including the actual address where service was transmitted listed in the affirmation of service below. I understand that the Workers' Compensation Law provides for substantial penalties for instituting or continuing proceedings without reasonable grounds and/or for the purpose of delay. I understand that if this application is withdrawn for any reason or if any of the issues raised are resolved by the parties, I must immediately notify the Board and the necessary parties of interest served in writing.

Preparer's Signature: _____ Date Prepared (mm/dd/yyyy): _____

Print Name: _____ Title: _____ Telephone No.: _____

Address: _____

## PROOF OF SERVICE

**AFFIRMATION**

I hereby affirm under penalty of perjury that I have complied with the filing and service requirements as set forth in 12 NYCRR 300.13(b)(2)(iv) and (3) for this *Application for Reconsideration/Full Board Review* in the manner set forth below and I understand that this document may be filed in an action or proceeding in a court of law.

A. I filed the *Application for Board Review* with the Board on (**date - mm/dd/yyyy**) _____ by (**pick one method**):

- ☐ Mail to PO Box 5205, Binghamton, NY 13902 (for unrepresented claimants only)
- ☐ Email at wcbclaimsfiling@wcb.ny.gov
- ☐ WCB Web Upload link (https://wcbdoc.services.conduent.com)
- ☐ **Workers' Compensation Discrimination Claim**: Mail to Discrimination Unit, PO Box 9029, Endicott, NY 13761-9029
- ☐ **Disability Benefits**: Mail to Disability Benefits Bureau, PO Box 9029, Endicott, NY 13761-9029

B. I served the *Application for Board Review* on (**date - mm/dd/yyyy**) _____ upon (attach additional sheets if necessary):

Name: _____ by (method): _____ at (address): _____

Name: _____ by (method): _____ at (address): _____

Name: _____ by (method): _____ at (address): _____

Name: _____ by (method): _____ at (address): _____

Name: _____ by (method): _____ at (address): _____

Name: _____ by (method): _____ at (address): _____

Name: _____ by (method): _____ at (address): _____

Name: _____ by (method): _____ at (address): _____

I certify that any party served by email or other electronic means provided explicit permission to receive service by such means.

I certify that service of this *Application for Reconsideration/Full Board Review*, as set forth above, was completed within thirty days from the filing of the decision that is the subject of this application.

Date (mm/dd/yyyy): _____ Signature: _____

Print Name: _____