NEW YORK STATE | Workers' Compensation Board

REQUEST FOR FURTHER ACTION BY LEGAL COUNSEL
RFA-1LC

CASE INFORMATION

WCB Case ID	Date of Injury	Claim Admin Claim #
55555555	01/01/2020	555

Claimant Name Fake, Case

Claimant Counsel Name Jane Testing **Representative ID**

Employer Name NYS WCB Fake Case Primary Employer

Insurer Name WCB Test Insurer Attn: Michael **Insurer ID**

Claim Admin Name WCB Test Insurer Attn: Michael **Claim Admin ID**

RFA-1LC SUMMARY

Summary of selected request reason(s):

1. *Claimant, Attorney, or Licensed Representative has not been paid per decision or was paid late*
2. *Claimant has discontinued or settled a lawsuit pertaining to this case*

Additional proposed findings:

1. *Establish average weekly wage (AWW)*

RFA–1LC REQUEST DETAILS

1. Claimant, Attorney, or Licensed Representative has not been paid per decision or was paid late

Form ID	Received Date	Document ID	Category of Payment	Unpaid Amount	Late Payment Amount	Late Payment Date
EC-23			Award of Compensation	$2000	$100	10/29/2024
			Medical & Transportation	$100	$25	10/29/2024

Additional information related to this reason: Entering additional information related to this reason free form text box for example. Entering additional information related to this reason free form text box for example. Entering additional information related to this reason free form text box for example.

2. Claimant has discontinued or settled a lawsuit pertaining to this case

The settlement documents listed below are required.

Documentation: Closing statement and consent letter

ADDITIONAL PROPOSED FINDINGS

1. Establish average weekly wage (AWW)

Will the proposed AWW result in an adjustment to prior payments or continuing payments? No

Primary employer AWW: $500.00

The AWW was calculated using the following method: Per First Report of Injury (FROI)/Subsequent Report of Injury (SROI)

SUPPORTING DOCUMENTATION

Referenced Document(s):

Form ID	Medical Service Date	Document ID	Received Date
ATTY-CORR			

CERTIFICATION

The following request(s) require certification:

1. *Claimant, Attorney, or Licensed Representative has not been paid per decision or was paid late*
2. *Claimant has discontinued or settled a lawsuit pertaining to this case*
3. *Additional Proposed Findings: Establish average weekly wage (AWW)*

I certify that I have attempted to contact the opposing party(ies) or its representative(s) to discuss the reason(s) selected, and have waited at least 24 hours for a response, but that no discussion was forthcoming.

First Name	Last Name	Name Unknown	Organization Name	Date	Phone	Email
John	Tester		ABC Test LLC	10/30/2024	5184578888	test@email.com

ATTESTATION

I affirm that:

(1) my statements are true and correct, and

(2) I am authorized to submit this request, and

(3) this request for Board action is based upon reasonable grounds, has been submitted with my client's consent, and that this form with attachment(s) has been provided to the opposing party(ies), and

(4) I accept that the electronic submission of this form to the Workers' Compensation Board is equivalent to placing my signature on the request.

Claimant Counsel Name: Jane Testing **Date:** 11/01/2024

Phone Number: 5184570000 **Ext.:** 18