

**STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
FRAUD COMPLAINT**

Date: _____

To: Workers' Compensation Fraud Inspector General, 20 Park Street, Albany, NY 12207

Complaint received from: Name _____

Address: _____ Tel. No. _____

Complaint taken by: _____
(If applicable) Name Title/Dept. Tel. No.

District Office: _____ Complaint received via: Mail Telephone Other

Complaint Concerns: Attorney/Lic. Rep. Carrier Claimant Employer Health Provider

Name of person/firm complained of: _____

Address: _____ Tel. No. _____

Describe alleged fraudulent activity: (Please provide as much detail as possible, and include names, dates, documents and witnesses; attach further information, if necessary.)

Claim Information:

Name of Claimant: _____

Address: _____

WCB Case No: _____ Social Security No: _____

Name of employer at time of injury: _____

Address: _____

Name of Insurance Carrier: _____

Address: _____

Was claimant working while receiving benefits? Yes No. If yes, indicate:

Name of Employer: _____

Address: _____

Has any of this information been reported to any other law enforcement agency? If so, state agency, contact person and telephone.
