AGREEMENT TO PAY MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE OR IF COMPENSATION CLAIM IS DISALLOWED

WCB CASE NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.

CLAIMANT	NAME	ADDRESS	APT. NO.
EMPLOYER			
INSURANCE CARRIER			

In the event I fail to prosecute the claim for workers' compensation for this illness or condition or it is determined by the Workers' Compensation Board that the illness or condition is not a result of a compensable workers' compensation case, I,_____, hereby agree to pay (name)_____(address)_____ his/her usual and customary fees for services rendered to the above named claimant in the above identified case.

Date:_____ Signature_____

If signed by other than claimant, print below the name, address, and relationship of signer.

Name and Address_____ Relationship_____

A-9 (12-99) **Prescribed by Chair Workers' Compensation Board State of New York**

NY-WCB