PPO – EMPLOYER AFFIRMATION A

Mail, fax or email information to:
Division of Policy and Program Development
(Attn: Mark Arunasalem)
State of New York Workers' Compensation Board
100 Broadway-Menands, Albany NY 12241
Email: MCNetworks@wcb.ny.gov
Fax: (518) 473-6379

In the Matter of Preferred Provider Organization Participation
(**PPO Name:** _____)

By EMPLOYER **(Please enter name and address)**

Name: _____

Address: _____

_____

(Name of Employer Official), attests to the following:

1. I am the _____ of _____
(**Title**) (**Name of Employer**)
and I file this affirmation in accordance with Article 10-A of the Workers' Compensation Law and 12 NYCRR 325-8.2.

[Please circle and utilize the applicable phrase]:

2. I attest that _____ has no unionized employees.
(**Name of Employer**)

OR

3. I attest that _____ has unionized employees, however,
(**Name of Employer**)
such employees are not participating in the Preferred Provider Organization ("PPO") program.

I am aware that no unionized employees may participate in the PPO program until such arrangement is collectively bargained with the recognized or exclusive bargaining representative of the covered employees. Such negotiation and consent must be evidenced in a notarized affirmation signed by the collective bargaining agent, agreeing to the selection of the PPO and setting forth the duration of the agreement.

_____ _____
Signature of Employer Official (Type or print name of Employer Official)

Sworn to me this day of _____.

Notary Signature and Stamp

PPO – EMPLOYER AFFIRMATION B

Mail, fax or email information to:
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State of New York Workers' Compensation Board
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Fax: (518) 473-6379

In the Matter of Preferred Provider Organization Participation
By EMPLOYER **(Please enter name and address)**

Name: _____

Address: _____

_____

-and-

UNION _____ (Union Name)

1. I, _____ am the _____
(**Name of Union Official**) (**Title of Union Official**)
of _____, ("the Union") which is the recognized or
(**Name of Union**)
exclusive collective bargaining representative for the members of the Union who are employed by _____ ("the Employer") and who will be covered by this Preferred
(**Name of Employer**)
Provider Organization ("PPO") arrangement. I file this affirmation in accordance with Article 10-A of the Workers' Compensation Law and 12 NYCRR 325-8.2.

2. I, _____ am the _____ of the
(**Name of Employer Official**) (**Title**)
employer and I file this affirmation in accordance with Article 10-A of the Workers' Compensation Law and 12 NYCRR 325-8.2.

3. We affirm that the Employer and the Union engaged in negotiations with respect to the selection of a certified PPO network and have agreed to have _____
(**Name of PPO**)
as the exclusive source for all initial treatment of work-related injuries and illnesses suffered by members of the Union.

4. We affirm that the duration of this PPO agreement is from _____ to _____ .
Any subsequent agreements will be made subject to the same prior review and approval process by the Employer and the Union.

_____ _____
Signature of Union Official Signature of Employer Official

_____ _____
(Please type or print union official name) (Please type or print employer official name)

Sworn to me this day of _____.

Notary Signature and Stamp