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

WCB CASE# (if known)	CARRIER CASE# (if known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOCIAL SECURITY#

	NAME	ADDRESS
CLAIMANT		
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 of doctor) ____(address of doctor) ____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: name, address, and relationship of signer.

__________________________________ ____

Name Relationship

____

Address

Prescribed by Chairman
Workers' Compensation Board
State of New York

A-9 (10-84)
NY/WC