

**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