PPO – EMPLOYER AFFIRMATION B

Bureau of Health Management
State of New York Workers' Compensation Board
100 Broadway-Menands, Albany, NY 12241

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