	Workers' Compensation Board
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State of New York - Workers' Compensation Board Subsequent Report of Injury Report Type (MTC) AC-Acquisition/Indemnity Ceased

S7744542

This paper contains information that has been provided electronically to the Board. Do <u>not</u> serve a copy of this on the Board.
The Claim Administrator who acquired the claim has indicated that indemnity benefits are not being paid and the previous Claim
Administrator did not file a suspension notice.

Employee Name John	T Doe							
WCB Case Number (JC	N) <u>G2687883</u>		Date of Injury 09/09/2020					
Claim Administrator Cla	im Number BRI-28		Maintenance Type Code Date 10/15/2020					
Claim Type <u>M - Medical</u>	Only		WCB Received Date	10/15/2020				
Agreement to Compens	ate L - With Liability							
		INSURER INFORI	MATION					
FEIN xxxxx6212			Insurer ID	W212500				
	CLA	IM ADMINISTRATOR	INFORMATION					
Name All American Ir	nsurance Company	FEIN	xxxxx6212					
Claim Representative Na	ame Mary Clark	Postal Code	12202					
Claim Representative Business Phone Number 5185551212								
E-mail Address mclark@	@allamerican.com		Claim Admin ID W212500					
Late Reason								
		EMPLOYEE INFOR	RMATION					
First Name	John		Middle Name/Initial					
Last Name	Doe		Suffix					
Date of Birth	09/15/1980							
Employee ID Type	<u>S - Employee Social Se</u>	ecurity Number	Employee ID	_xxxx5210				

CLAIM INFORMATION							
Initial Date Employer Had Kn	owledge of Date of Disability	_0!	9/10/2020	Employment Status	1 - Regular/Full-time Employee		
Current Date Employer Had	Disability 0	9/10/2020	Work Week Type	S - Standard Work Week			
Work Days Scheduled (S-Sche		WTFS		Wage Period	01 - Weekly		
Calculated Wage		\$1,200.00		Anticipated Wage Lo	SS		
Calculated Weekly Compensation	ation Amount	<u>\$1,000.00</u>					
Employer Paid Salary Prior T	o Acquisition						
Date Claim Administrator Not	tified of Employee Represent	ation					
EMPLOYEE INJURY							
Full Wages Paid for Date of Ir	njury <u>Yes</u>						
Type of Loss 01 - Traumation	c Injury		Date	of Maximum Medical	Improvement		
PERMANENT IMPAIRMENT					p		
Impairment Percentage	Body Part Location	n	Body Part				
Death Result of Injury	Date of Death		Num	ber of Dependents			
WORK STATUS							
Initial Date Disability Began	09/10/2020						
Initial RTW Date			Lat	est RTW/Status Date			
Initial RTW Type Code			Lat	est RTW Type Code			
Initial RTW Physical Restricti	ons		Lat	est RTW Physical Res	trictions		
Initial RTW With Same Emplo	oyer		Lat	est RTW With Same E	mployer		
BENEFITS							
Reduced Benefit Amount							
Estimated Gross Weekly Am	t						
Overpayment Amount - Curre	ent						
Jurisdiction Claim Number -	Related						
Acquired Claim Last Known I	Indemnity Through Date						

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Benefits

Benefit Types										
Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	<u>W</u> e Effective Date	eekly Gross Amount	Effective Date	<u>Weekly Net</u> Amount	Benefit Payment Issue Date	Amount Paid

Other Benefits

Other Benefit Type	Amount							
PAYMENTS								
Award/Order Date								
Recoveries								
Recovery Type	Amount							
EMPLOYER / INSURED INFORMATION								
Employer FEIN xxxxx7766		Insured FEIN	xxxxx7766					
CONCURRENT EMPLOYER INFORMATION								
Name	Contact Bu	siness Phone	Wage					