Workers' Compensation Board

State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) CA-Change in Benefit Amount

S7745305

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.

The Claim Administrator has changed the net weekly amount from what was previously reported, but the benefit type has not changed.

Employee Name John T Doe

WCB Case Number (JCN) G2687906 **Date of Injury** 10/01/2020

Claim Administrator Claim Number VPAL126 **Maintenance Type Code Date** 12/29/2020

Claim Type I - Indemnity for Lost Time **WCB Received Date** 12/29/2020

Agreement to Compensate L - With Liability

INSURER INFORMATION

FEIN xxxxx6266 **Insurer ID** W010698

CLAIM ADMINISTRATOR INFORMATION

Name All American Insurance Company **FEIN** xxxxx6266

Claim Representative Name Mary Clark **Postal Code** 12202

Claim Representative Business Phone Number 5185185181

E-mail Address mclark@allamerican.com **Claim Admin ID** W010698

Late Reason

EMPLOYEE INFORMATION

First Name John **Middle Name/Initial** T

Last Name Doe **Suffix**

Date of Birth 08/19/1987

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx5432

CLAIM INFORMATION

Initial Date Employer Had Knowledge of Date of Disability 10/01/2020

Current Date Employer Had Knowledge of Current Date of Disability 10/01/2020

Work Days Scheduled (S-Scheduled N-Non Scheduled) S M T W T F S

Calculated Wage $4,000.00

Calculated Weekly Compensation Amount $4,000.00

Employer Paid Salary Prior To Acquisition

Date Claim Administrator Notified of Employee Representation

Employment Status 1 - Regular/Full-time Employee

Work Week Type S - Standard Work Week

Wage Period 01 - Weekly

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes

Type of Loss 01 - Traumatic Injury

Employer Paid Salary in Lieu of Compensation No

Date of Maximum Medical Improvement

PERMANENT IMPAIRMENT

Impairment Percentage	Body Part Location	Body Part

Death Result of Injury **Number of Dependents**

DEPENDENT/PAYEE

Dependent/Payee Relationship	First Name	Last Name	Date of Birth

BENEFITS

Reduced Benefit Amount R - Reclassification of Benefit

Non-Consecutive Period A - Adjustment/Credit/Redistribution

Overpayment Amount - Current $2,000.00

Benefit Change Reason Code C - Recalculation of Net Weekly Amount based on Wage Statement

Benefits

Benefit Types

080 - Employer's Liability

Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross Effective Date	Weekly Gross Amount	Weekly Net Effective Date	Weekly Net Amount	Benefit Payment Issue Date	Amount Paid
080	11/01/2020	11/30/2020	4	5	10/01/2020	$3,000.00	10/01/2020	$3,000.00	12/21/2020	$12,000.00

Benefits - A - Adjustments / C - Credits / R - Redistributions

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount

Other Benefits

Other Benefit Type	Amount

PAYMENTS

Award/Order Date _____

Recoveries

Recovery Type	Amount

Reduced Earnings

Actual Reduced Earnings	Reduced Earnings Week Start Date	Reduced Earnings Week End Date	Reduced Earnings Net Weekly Amount Due By Claim Administrator

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx9987 **Insured FEIN** xxxxx8776

CONCURRENT EMPLOYER INFORMATION

Name _____ **Contact Business Phone** _____ **Wage** _____