

State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) IP-Initial Payment

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 begun payment of indemnity benefits and payments are ongoing.

Employee Name John T Doe

WCB Case Number (JCN) G2687877 Date of Injury 08/08/2020

Claim Administrator Claim Number BRI-22 Maintenance Type Code Date 10/07/2020

Claim Type I - Indemnity for Lost Time WCB Received Date 10/07/2020

Agreement to Compensate L - With Liability

INSURER INFORMATION

FEIN xxxxx6212 Insurer ID W212500

CLAIM ADMINISTRATOR INFORMATION

Name All American Insurance Company FEIN xxxxx6212

Claim Representative Name Mark Clark Postal Code 12202

Claim Representative Business Phone Number 5185551212

E-mail Address mclark@allamerican.com Claim Admin ID W212500

Late Reason _____

EMPLOYEE INFORMATION

First Name John Middle Name/Initial T

Last Name Doe Suffix _____

Date of Birth 09/15/1950

Employee ID Type S - Employee Social Security Number Employee ID xxxxx2727

CLAIM INFORMATION

Initial Date Employer Had Knowledge of Date of Disability 08/09/2020 Employment Status 1 - Regular/Full-time Employee
 Current Date Employer Had Knowledge of Current Date of Disability _____ Number of Days Worked Per Week 5
 Pre-existing Disability _____ Work Week Type S - Standard Work Week
 Work Days Scheduled (S-Scheduled N-Non Scheduled)

S	M	T	W	T	F	S

 Wage Period 01 - Weekly
 Calculated Wage \$1,200.00 Denial Rescission Date _____
 Calculated Weekly Compensation Amount \$1,000.00
 Employer Paid Salary Prior To Acquisition _____
 Date Claim Administrator Notified of Employee Representation _____

EMPLOYEE INJURY

Full Wages Paid for Date of Injury No Employer Paid Salary in Lieu of Compensation No
 Type of Loss 01 - Traumatic Injury Date of Maximum Medical Improvement _____

PERMANENT IMPAIRMENT

Impairment Percentage	Body Part Location	Body Part

Death Result of Injury _____ Date of Death _____ Number of Dependents _____

DEPENDENT/PAYEE

Dependent/Payee Relationship	First Name	Last Name	Date of Birth

WORK STATUS

First Day of Disability After The Waiting Period _____
 Initial Date Last Day Worked 08/08/2020 Current Date Last Day Worked _____
 Initial Date Disability Began 08/09/2020 Current Date Disability Began _____
 Initial RTW Date _____ Latest RTW/Status Date _____
 Initial RTW Type Code _____ Latest RTW Type Code _____
 Initial RTW Physical Restrictions _____ Latest RTW Physical Restrictions _____
 Initial RTW With Same Employer _____ Latest RTW With Same Employer _____

BENEFITS

Reduced Benefit Amount _____ Non-Consecutive Period _____
 Estimated Gross Weekly Amt. _____
 Overpayment Amount - Current _____

Benefits

Benefit Types										
070 - Temporary Partial										
Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross		Weekly Net		Benefit Payment Issue Date	Amount Paid
					Effective Date	Amount	Effective Date	Amount		
070	09/01/2020	09/02/2020	1	1	09/01/2020	\$900.00	09/01/2020	\$900.00	09/01/2020	\$900.00

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

PAYMENTSAward/Order Date 09/01/2020

Payment Reasons						
070 - Temporary Partial						
Payment Reason Code	Payee	Start Date	Through Date	Issue Date	Amount Paid	
070	John T Doe	09/01/2020	09/02/2020	09/01/2020	\$900.00	

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 INFORMATIONEmployer FEIN xxxxx4444Insured FEIN xxxxx1111**CONCURRENT EMPLOYER INFORMATION**

Name _____ Contact Business Phone _____ Wage _____