NEW YORK STATE Workers' Compensation Board

S7744536

State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) 02-Change

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

Pursuant to 12 NYCRR § 300.22, when the claim administrator is changing the Agreement to Compensate Code from Without Liability to With Liability, or Denial Rescission Date is added, this notice must be served on the claimant and his or her attorney or licensed representative, if any, within one business day of the date it is filed electronically with the chair.

Employee Name John T Doe

WCB Case Number (JCN) G2687881 **Date of Injury** 06/06/2020

Claim Administrator Claim Number BRI-26 **Maintenance Type Code Date** 10/14/2020

Claim Type P - Indemnity with No Lost Time Beyond Waiting Period **WCB Received Date** 10/14/2020

Agreement to Compensate W - Without Liability

INSURER INFORMATION

FEIN xxxxx6212 **Insurer ID** W212500

CLAIM ADMINISTRATOR INFORMATION

Name All American Insurance Company **FEIN** xxxxx6212

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

Claim Representative Business Phone Number 5185551212

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

Late Reason

DENIAL REASONS

Partial Denial Reason

Partial Denial Effective Date

Full Denial Effective Date

Full Denial Reason

Denial Reason Narrative

EMPLOYEE INFORMATION

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

Last Name Doe **Suffix**

Date of Birth 09/15/1965

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx5544

CLAIM INFORMATION

Initial Date Employer Had Knowledge of Date of Disability 06/06/2020

Current Date Employer Had Knowledge of Current Date of Disability 06/06/2020

Pre-existing Disability

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

Calculated Wage $1,200.00

Calculated Weekly Compensation Amount $1,000.00

Employer Paid Salary Prior To Acquisition

Date Claim Administrator Notified of Employee Representation

Employment Status 1 - Regular/Full-time Employee

Number of Days Worked Per Week 5

Work Week Type S - Standard Work Week

Wage Period 01 - Weekly

Anticipated Wage Loss

Denial Rescission Date

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes

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
10%		11 - Skull

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 06/06/2020

Initial Date Last Day Worked 06/06/2020

Initial Date Disability Began

Initial RTW Date

Initial RTW Type Code

Initial RTW Physical Restrictions

Initial RTW With Same Employer

Current Date Last Day Worked

Current Date Disability Began

Latest RTW/Status Date

Latest RTW Type Code

Latest RTW Physical Restrictions

Latest RTW With Same Employer

SUSPENSION

Suspension Effective Date **Suspension Reason Code - Full**

Suspension Reason

BENEFITS

Reduced Benefit Amount _____ **Non-Consecutive Period** _____

Estimated Gross Weekly Amt. _____

Overpayment Amount - Current _____

Jurisdiction Claim Number - Related _____

Acquired Claim Last Known Indemnity Through Date _____

Benefit Change Reason Code _____

Benefits

Benefit Types										
070 - Temporary Partial										
Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	**Weekly Gross** Effective Date	Amount	**Weekly Net** Effective Date	Amount	Benefit Payment Issue Date	Amount Paid
070	07/01/2020	07/31/2020	4	4	07/01/2020	$1,000.00	07/01/2020	$1,000.00	07/01/2020	$1,000.00

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 07/01/2020 **Lump Sum Payment/Settlement** _____

Payment Reasons					
070 - Temporary Partial					
Payment Reason Code	Payee	Start Date	Through Date	Issue Date	Amount Paid
070	John T Doe	07/01/2020	07/31/2020	07/01/2020	$1,000.00

Recoveries

Recovery Type	Amount

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx5777 **Insured FEIN** xxxxx3232

CONCURRENT EMPLOYER INFORMATION

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

CHANGE DATA ELEMENTS

Change Data Element/Segment Number	Change Reason Code
0424 - Number of Dependent/Payee Relationships	D - Delete
0066 - Full Wages Paid for Date of Injury Indicator	U - Update
0297 - Initial Date of Lost Time	A - Add