NEW YORK STATE | Workers' Compensation Board

S7744527

State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) CB-Change in Benefit Type

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 benefit type from what was previously reported.

Employee Name John T Doe

WCB Case Number (JCN) G2687882

Date of Injury 08/08/2020

Claim Administrator Claim Number BRI-27

Maintenance Type Code Date 10/14/2020

Claim Type I - Indemnity for Lost Time

WCB Received Date 10/14/2020

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 Mary 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 09/15/1990

Employee ID Type S - Employee Social Security Number

Employee ID xxxxx2323

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

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

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 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
25%	R - Right	36 - Finger(s) other than thumb

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 ______

Current Date Last Day Worked ______

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 ______

Benefit Change Reason Code ______

Benefits

Benefit Types
030 - Permanent Partial/Scheduled
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		
030	09/01/2020	09/02/2020	1	1	09/01/2020	$1,000.00	09/01/2020	$1,000.00	09/01/2020	$1,000.00
070	09/01/2020	09/02/2020	1	1	09/01/2020	$1,000.00	09/01/2020	$1,000.00	09/01/2020	$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 09/01/2020

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 xxxxx6232

Insured FEIN xxxxx9565

CONCURRENT EMPLOYER INFORMATION

Name ______

Contact Business Phone ______

Wage ______