New York State Workers' Compensation Board

S7744516

State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) SU-Sync Up

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Employee Name John T Doe

WCB Case Number (JCN) G2687878

Date of Injury 03/03/2020

Claim Administrator Claim Number BRI-23

Maintenance Type Code Date 10/08/2020

WCB Received Date 10/08/2020

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

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 09/15/1970

Employee ID Type S - Employee Social Security Number

Employee ID xxxxx2323

CLAIM INFORMATION

Employer Paid Salary Prior To Acquisition

EMPLOYEE INJURY

PERMANENT IMPAIRMENT

Impairment Percentage	Body Part Location	Body Part
10%	L - Left	13 - Ear(s)
50%	R - Right	36 - Finger(s) other than thumb

DEPENDENT/PAYEE

Dependent/Payee Relationship	First Name	Last Name	Date of Birth
41 - Son/Daughter (birth order 1)	John	Public	02/02/2002

WORK STATUS

Current Date Disability Began ____________

SUSPENSION

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

Suspension Reason

BENEFITS

Non-Consecutive Period A - Adjustment/Credit/Redistribution

Overpayment Amount - Current ____________

Benefits

Benefit Types											
070 - Temporary Partial											
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	
070	03/10/2020	03/11/2020	1	1	03/10/2020	$1,000.00	03/10/2020	$1,000.00	03/10/2020	$1,000.00	

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

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount
070 - Temporary Partial	C	P - Advance	03/10/2020	03/10/2020	$200.00

Other Benefits

Other Benefit Type	Amount

PAYMENTS

Lump Sum Payment/Settlement ____________

Recoveries

Recovery Type	Amount
840 - Unspecified Recovery	$25.00

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 xxxxx2121

CONCURRENT EMPLOYER INFORMATION

Name ____________________ **Contact Business Phone** ____________________ **Wage** ____________________