Workers' Compensation Board

State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) UR-Upon Request (Grandfathered)

S7744759

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Employee Name John T Doe

WCB Case Number (JCN) G2687912 **Date of Injury** 01/01/2010

Claim Administrator Claim Number VPAL134 **Maintenance Type Code Date** 12/04/2020

Claim Type I - Indemnity for Lost Time **WCB Received Date** 12/04/2020

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 5185185181

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

Late Reason

DENIAL REASONS

Partial Denial Reason

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 02/19/1970

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx1234

CLAIM INFORMATION

Initial Date Employer Had Knowledge of Date of Disability 01/01/2010

Current Date Employer Had Knowledge of Current Date of Disability 01/01/2010

Pre-existing Disability

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

Calculated Wage

Calculated Weekly Compensation Amount

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

Denial Rescission Date

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 **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

Initial Date Disability Began 01/01/2010

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

BENEFITS

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

Estimated Gross Weekly Amt. _____

Overpayment Amount - Current _____

Jurisdiction Claim Number - Related _____

Benefits

Benefit Types										
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

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

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx8768 **Insured FEIN** xxxxx8768

CONCURRENT EMPLOYER INFORMATION

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