State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) PD-Partial Denial

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 denied indemnity benefits in part or whole but is not denying medical benefits. If Claim Administrator denies medical benefits, they will file Form C-8.1

Employee Name David Davey Jr.

WCB Case Number (JCN) G0760020 **Date of Injury** 10/01/2012

Claim Administrator Claim Number CTW080824 **Maintenance Type Code Date** 05/14/2013

Claim Type B - Became Medical Only **WCB Received Date** 05/14/2013

INSURER INFORMATION

FEIN xxxxx5740 **Insurer ID** W016505

CLAIM ADMINISTRATOR INFORMATION

Name All Amercia Insurance Co **FEIN** xxxxx5740

Claim Representative Name Mary Clark **Postal Code** 12110

Business Phone Number 5187855000 **Fax Number** 5187855001

E-mail Address mclark@allamerica.com **Claim Admin ID** W016505

Late Reason

PARTIAL DENIAL REASON

Partial Denial Reason A - Denying Indemnity in Whole, not Medical

Denial Reason Narrative

Carrier is now accepting claim, however, not lost time because claimant quit his job; carrier raises voluntary removal from labor market.

EMPLOYEE INFORMATION

First Name David **Middle Name/Initial**

Last Name Davey **Suffix** Jr.

Date of Birth 11/01/1957

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx6745

CLAIM INFORMATION

Date Employer Had Knowledge of Date of Disability 10/01/2012

Employment Status 1 - Regular/Full-time Employee

Pre-existing Disability No

Number of Days Worked Per Week 5

Calculated Wage $1,050.00

Wage Period 01 - Weekly

Calculated Weekly Compensation Amount $700.00

Anticipated Wage Loss

Employer Paid Salary Prior To Acquisition

Denial Rescission Date

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

Death Result of Injury **Date of Death** **Number of Dependents** 0

Dependent/Payee Relationship

WORK STATUS

Initial Date of Lost Time 10/02/2012

Current Date Disability Began

Initial Date Disability Began 10/02/2012

Current Return to Work Date

Initial Return to Work Date

Return To Work Type **Physical Restrictions** **Return To Work Same Employer**

BENEFITS

Reduced Benefit Amount

Agreement to Compensate

Estimated Gross Weekly Amt.

Benefits

Benefit Types										
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

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 xxxxx5483 **Insured FEIN** xxxxx5483

CONCURRENT EMPLOYER INFORMATION

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