

State of New York - Workers' Compensation Board
Subsequent Report of Injury
Report Type (MTC) SJ-Suspended
Pending Appeal or Judicial Review

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 suspended indemnity benefits for the reasons reflected in the Suspension Section of this document.

Employee Name Henry Mitchell Sr.

WCB Case Number (JCN) G0760037 **Date of Injury** 02/01/2013

Claim Administrator Claim Number 984562X1 **Maintenance Type Code Date** 05/07/2013

Claim Type L - Became Lost Time **WCB Received Date** 05/07/2013

INSURER INFORMATION

FEIN xxxxx3504 **Insurer ID** W010003

CLAIM ADMINISTRATOR INFORMATION

Name Triad Group **FEIN** xxxxx1658

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

Business Phone Number 5187855000 **Fax Number** 5187855001

E-mail Address mclark@allamerica.com **Claim Admin ID** T100068

Late Reason _____

EMPLOYEE INFORMATION

First Name Henry **Middle Name/Initial** _____

Last Name Mitchell **Suffix** Sr.

Date of Birth 11/01/1987

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

CLAIM INFORMATION

Date Employer Had Knowledge of Date of Disability 02/01/2013 **Employment Status** 1 - Regular/Full-time Employee

Calculated Wage \$1,200.00 **Wage Period** 01 - Weekly

Calculated Weekly Compensation Amount \$792.07

Employer Paid Salary Prior To Acquisition _____

Date Claim Administrator Notified of Employee Representation _____

EMPLOYEE INJURYFull Wages Paid for Date of Injury YesType of Loss 01 - Traumatic Injury

Date of Maximum Medical Improvement _____

Death Result of Injury _____ Number of Dependents 0

Dependent/Payee Relationship _____

WORK STATUSInitial Date Disability Began 02/02/2013**BENEFITS**Reduced Benefit Amount _____ Agreement to Compensate L - With Liability

Estimated Gross Weekly Amt. _____

Benefits

Benefit Types											
050 - Temporary Total											
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			
050	02/02/2013	03/31/2013	8	0	02/02/2013	\$792.07	02/02/2013	\$792.07	03/31/2013	\$6,336.56	

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

PAYMENTSAward/Order Date 03/31/2013**Recoveries**

Recovery Type	Amount

Reduced Earnings

Week Number	Actual Reduced Earnings

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx8765

Insured FEIN xxxxx8765

CONCURRENT EMPLOYER INFORMATION

Name _____ Contact Business Phone _____ Wage _____

