

State of New York - Workers' Compensation Board
Subsequent Report of Injury
Report Type (MTC) IP-Initial Payment

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 begun payment of indemnity benefits and payments are ongoing.

Employee Name Henry A 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** A

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

Pre-existing Disability No **Number of Days Worked Per Week** 5

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

Calculated Weekly Compensation Amount \$792.07 **Denial Rescission Date** _____

Employer Paid Salary Prior To Acquisition _____

Date Claim Administrator Notified of Employee Representation _____

EMPLOYEE INJURYFull Wages Paid for Date of Injury YesEmployer Paid Salary in Lieu of Compensation NoType of Loss 01 - Traumatic Injury

Date of Maximum Medical Improvement _____

PERMANENT IMPAIRMENT

Impairment Percentage _____ Body Part _____

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

Dependent/Payee Relationship _____

WORK STATUSInitial Date of Lost Time 02/02/2013 Current Date Last Day Worked _____Initial Date Last Day Worked 02/01/2013 Current Date Disability Began _____Initial Date Disability Began 02/02/2013 Current Return to Work Date _____

Initial Return to Work Date _____

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

BENEFITSReduced Benefit Amount _____ Agreement to Compensate W - Without Liability

Estimated Gross Weekly Amt. _____ Non-Consecutive Period _____

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	02/15/2013	2	4	02/02/2013	\$792.07	02/02/2013	\$792.07	02/15/2013	\$2,217.80

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 _____

Payment Reasons

050 - Temporary Total

Payment Reason Code	Payee	Start Date	Through Date	Issue Date	Amount Paid
050	Henry Mitchell Sr.	02/02/2013	02/15/2013	02/15/2013	\$2,217.80

Recoveries

Recovery Type	Amount

Reduced Earnings

Week Number	Actual Reduced Earnings

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx8765Insured FEIN xxxxx8795

CONCURRENT EMPLOYER INFORMATION

Name _____ Contact Business Phone _____ Wage _____