WORKERS' COMPENSATION BOARD

State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) IP-Initial Payment

S143

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 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

PERMANENT IMPAIRMENT

Impairment Percentage

Body Part

Death Result of Injury

Date of Death

Number of Dependents 0

Dependent/Payee Relationship

WORK STATUS

Initial Date of Lost Time 02/02/2013

Initial Date Last Day Worked 02/01/2013

Initial Date Disability Began 02/02/2013

Initial Return to Work Date

Current Date Last Day Worked

Current Date Disability Began

Current Return to Work Date

Return To Work Type

Physical Restrictions

Return To Work Same Employer

BENEFITS

Reduced 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 Effective Date	Weekly Gross Amount	Weekly Net Effective Date	Weekly Net Amount	Benefit Payment Issue Date	Amount Paid
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 xxxxx8765 **Insured FEIN** xxxxx8795

CONCURRENT EMPLOYER INFORMATION

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