*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** _____