

**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** JOHN DOE Scenario 2.2

**WCB Case Number (JCN)** G0055555 **Date of Injury** 08/01/2012

**Claim Administrator Claim Number** TW0892356 **Maintenance Type Code Date** 08/17/2012

**Claim Type** L - Become Lost Time **WCB Received Date** filled by WCB

**INSURER INFORMATION**

**FEIN** xxxxx6789 **Insurer ID** W123456

**CLAIM ADMINISTRATOR INFORMATION**

**Name** ALL AMERICAN INSURANCE COMPANY **FEIN** xxxxx6789

**Claim Representative Name** MARY CLARK **Postal Code** 12110

**Business Phone Number** 5187855000 **Fax Number** 5187855001

**E-mail Address** mclark@allamerican.com **Claim Admin ID** W123456

**Late Reason** \_\_\_\_\_

**EMPLOYEE INFORMATION**

**First Name** JOHN **Middle Name/Initial** \_\_\_\_\_

**Last Name** DOE Scenario 2.2 **Suffix** \_\_\_\_\_

**Date of Birth** 11/01/1977

**Employee ID Type** A - ID Assigned by Jurisdiction **Employee ID** 771101JDOE

**CLAIM INFORMATION**

**Date Employer Had Knowledge of Date of Disability** 08/01/2012 **Employment Status** 1 - Full Time

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

**Work Days Scheduled** (S-Scheduled N-Non Scheduled) S M T W T F S  
N S S S S S N **Work Week Type** S - Standard Work Week

**Calculated Wage** \$1,050.00 **Wage Period** 01 - Weekly

**Calculated Weekly Compensation Amount** \$700.00 **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 No

Employer Paid Salary in Lieu of Compensation No

Type of Loss 01 - Trauma

Date of Maximum Medical Improvement \_\_\_\_\_

**PERMANENT IMPAIRMENT**

Impairment Percentage \_\_\_\_\_ Body Part \_\_\_\_\_

Death Result of Injury \_\_\_\_\_ Date of Death \_\_\_\_\_ Number of Dependents \_\_\_\_\_

Dependent/Payee Relationship \_\_\_\_\_

**WORK STATUS**

Initial Date of Lost Time 08/01/2012 Current Date Last Day Worked 08/07/2012

Initial Date Last Day Worked 08/01/2012 Current Date Disability Began 08/08/2012

Initial Date Disability Began 08/01/2012 Latest Return to Work Status Date \_\_\_\_\_

Initial Return to Work Date 08/06/2012

Return To Work Type \_\_\_\_\_ Physical Restrictions \_\_\_\_\_ Return To Work Same Employer \_\_\_\_\_

**BENEFITS**

Reduced Benefit Amount \_\_\_\_\_ Agreement to Compensate L - With Liability

Estimated Gross Weekly Amt. \_\_\_\_\_ Non-Consecutive Period B - Benefit Period

**Benefits**

| Benefit Types           |            |              |             |            |                |          |                |          |                            |             |
|-------------------------|------------|--------------|-------------|------------|----------------|----------|----------------|----------|----------------------------|-------------|
| 050 - Temporary Total   |            |              |             |            |                |          |                |          |                            |             |
| 070 - Temporary Partial |            |              |             |            |                |          |                |          |                            |             |
| 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                     | 08/01/2012 | 08/03/2012   | 0           | 3          | 08/01/2012     | \$700.00 | 08/01/2012     | \$700.00 | 08/17/2012                 | \$420.00    |
| 070                     | 08/08/2012 | 08/16/2012   | 1           | 2          | 08/08/2012     | \$350.00 | 08/08/2012     | \$350.00 | 08/17/2012                 | \$490.00    |

**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   |          |            |              |            |             |
| 070 - Temporary Partial |          |            |              |            |             |
| Payment Reason Code     | Payee    | Start Date | Through Date | Issue Date | Amount Paid |
| 050                     | John Doe | 08/01/2012 | 08/03/2012   | 08/17/2012 | \$420.00    |
| 070                     | John Doe | 08/08/2012 | 08/16/2012   | 08/17/2012 | \$490.00    |

**Recoveries**

| Recovery Type | Amount |
|---------------|--------|
|               |        |

**Reduced Earnings**

| Week Number | Actual Reduced Earnings |
|-------------|-------------------------|
|             |                         |

**EMPLOYER / INSURED INFORMATION**

Employer FEIN xxxxx8765

Insured FEIN xxxxx8765

**CONCURRENT EMPLOYER INFORMATION**

Name Apple Supermarkets Contact Business Phone 5185555555 Wage \$150.00