

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

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 made payment(s) as reflected in Benefits and/or Payments Section of this document.

Employee Name JOHN DOE Scenario 7-2

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

Claim Administrator Claim Number TW0892356 **Maintenance Type Code Date** 01/03/2013

Claim Type I - Indemnity for Lost Time **WCB Received Date** 02/01/2013

Agreement to Compensate W - Without Liability

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 7-2 **Suffix** _____

Date of Birth 11/01/1977

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

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 Yes

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

First Day of Disability After The Waiting Period 08/02/2012

Latest Return to Work Status Date _____

Initial Date Disability Began 08/02/2012

Initial Return to Work Date _____

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

BENEFITS

Reduced Benefit Amount _____

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	01/03/2013	01/03/2013								\$18,000.00

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
340 - Total Claimant's Legal Expense	\$2,000.00

PAYMENTS

Award/Order Date 12/31/2012

Lump Sum Payment/Settlement SF - Settlement Full

Payment Reasons

050 - Temporary Total

340 - Total Claimant's Legal Expense

Payment Reason Code	Payee	Start Date	Through Date	Issue Date	Amount Paid
050	John Doe	01/03/2013	01/03/2013	01/03/2013	\$18,000.00
340	Attorney Doe	01/03/2013	01/03/2013	01/03/2013	\$2,000.00

Recoveries

Recovery Type	Amount

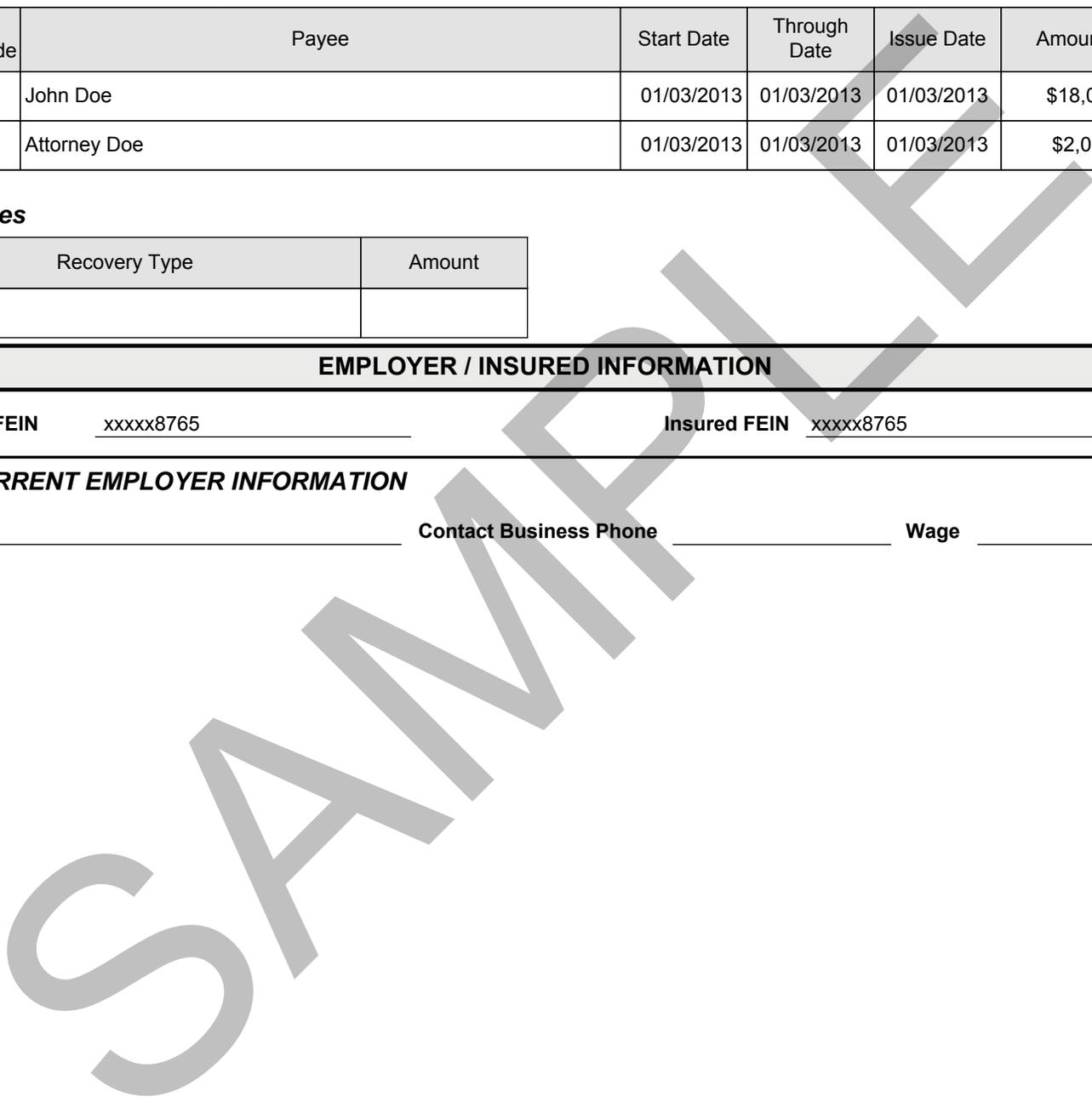
EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx8765

Insured FEIN xxxxx8765

CONCURRENT EMPLOYER INFORMATION

Name _____ Contact Business Phone _____ Wage _____



TO THE CLAIMANT

Your employer or its insurance carrier has started to make payments without prejudice for the accident which occurred on the date shown below. Under this program, an employer or its insurance carrier begins making payments to you in order to provide you with temporary funds, while still investigating the circumstances of the reported accident or injury, including an investigation as to whether it is the correct insurance carrier. You should have received a notice from the employer or carrier indicating that payments have begun. The reason that you are receiving payments should be identified on the notice you received from the employer or insurance carrier. Contact your employer or its insurance carrier, if you have not received this notice. If you have not started to receive payments, contact the nearest office of the Workers' Compensation Board immediately.

If the employer or insurance carrier is still investigating the circumstances of the reported accident or injury, payments are made pursuant to Workers' Compensation Law 21-a. **The payment of temporary compensation is not an admission by the employer that it is liable for your injury or injuries.** Your acceptance of temporary payments will not prejudice your claim for further benefits. Your employer may request that you enter into an agreement in order to ensure the continuation of payments of temporary compensation. Temporary compensation and prescribed medical payments may continue for up to one year from the date of first payment, or until your employer contests your right to compensation, or until the Board's determination of your claim, whichever is first. Your employer may stop temporary payments at any time provided it sends you a notice of termination of temporary payments within five days after the last payment is made. If your employer stops temporary payments, it will notify you in writing whether or not it is contesting your claim. (Contact the Board immediately if your payments stop and you do not receive a written notice from the employer.) The Board will then notify you of any further action taken in your case. If your employer does not send you a notice of termination of temporary benefits within one year after the start of payments, your employer will be considered to have admitted liability for your claim.