

State of New York - Workers' Compensation Board
Subsequent Report of Injury
Report Type (MTC) RB-Reinstatement of Benefits

*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 resumed payment of indemnity benefits.*

Employee Name JOHN DOE Scenario 8-4

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

Claim Administrator Claim Number TW0892356 **Maintenance Type Code Date** 02/12/2013

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

Agreement to Compensate L - With 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 8-4 **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

Work Days Scheduled (S-Scheduled N-Non Scheduled) SMTWTFSS **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 _____ Number of Dependents _____

Dependent/Payee Relationship _____

WORK STATUS

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

Current Date Last Day Worked _____

Initial Date Disability Began 08/02/2012

Current Date Disability Began 02/01/2013

Initial Return to Work Date _____

Latest Return to Work Status Date _____

Return To Work Type _____ Physical Restrictions _____

Return To Work Same Employer _____

BENEFITS

Reduced Benefit Amount _____ Non-Consecutive Period _____

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	08/02/2012	02/12/2013	6	2	08/02/2012	\$700.00	08/02/2012	\$700.00	02/12/2013	\$4,480.00

Benefits - Cumulative

Benefit Type	Start Date	Through Date	Claim Weeks	Claim Days	Amount Paid
070 - Temporary Partial	09/05/2012	01/18/2013	19	2	\$6,790.00

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

Payment Reason Code	Payee	Start Date	Through Date	Issue Date	Amount Paid
050	John Doe	02/01/2013	02/12/2013	02/12/2013	\$1,120.00

Recoveries

Recovery Type	Amount

Reduced Earnings

Week Number	Actual Reduced Earnings

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx8765Insured FEIN xxxxx8765
CONCURRENT EMPLOYER INFORMATION

Name _____ Contact Business Phone _____ Wage _____