

State of New York - Workers' Compensation Board
Subsequent Report of Injury
Report Type (MTC) UR-Upon Request

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Employee Name JOHN DOE Scenario 9-4

WCB Case Number (JCN) 5000999 **Date of Injury** 02/02/2004

Claim Administrator Claim Number TW0892356 **Maintenance Type Code Date** 11/19/2012

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

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 _____

DENIAL REASONS

Partial Denial Reason _____

Full Denial Effective Date _____

Full Denial Reason _____

Denial Reason Narrative _____

EMPLOYEE INFORMATION

First Name JOHN **Middle Name/Initial** _____

Last Name DOE Scenario 9-4 **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 02/02/2004 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 Work Week Type S - Standard Work Week
N S S S S S N Wage Period 01 - Weekly
 Calculated Wage \$600.00 Denial Rescission Date _____
 Calculated Weekly Compensation Amount \$400.00
 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 50.0% Body Part 42 - LowBack
 Death Result of Injury No Date of Death 11/14/2012 Number of Dependents _____
 Dependent/Payee Relationship _____

WORK STATUS

Initial Date of Lost Time 02/03/2004 Current Date Last Day Worked _____
 Initial Date Last Day Worked 02/02/2004 Current Date Disability Began _____
 Initial Date Disability Began 02/03/2004 Latest Return to Work Status Date _____
 Initial Return to Work Date _____
 Return To Work Type _____ Physical Restrictions _____ Return To Work Same Employer _____

SUSPENSION

Suspension Effective Date _____
 Suspension Reason _____

BENEFITS

Reduced Benefit Amount _____ Agreement to Compensate L - With Liability
 Estimated Gross Weekly Amt. _____ Non-Consecutive Period _____

Benefits

Benefit Types										
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		

Benefits - Cumulative

Benefit Type	Start Date	Through Date	Claim Weeks	Claim Days	Amount Paid
030 - Permanent Partial	08/19/2006	11/14/2012	325	2	\$65,080.00
050 - Temporary Total	02/03/2004	08/20/2004	28	4	\$11,520.00
070 - Temporary Partial	08/23/2004	08/18/2006	104		\$20,800.00

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 _____

Recoveries

Recovery Type	Amount

Reduced Earnings

Week Number	Actual Reduced Earnings

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx8765

Insured FEIN xxxxx8765

CONCURRENT EMPLOYER INFORMATION

Name _____ Contact Business Phone _____ Wage _____