

**State of New York - Workers' Compensation Board**  
**Subsequent Report of Injury**  
**Report Type (MTC) 02-Change**

*This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.*

Pursuant to 12 NYCRR § 300.22, when the claim administrator is changing the Agreement to Compensate Code from Without Liability to With Liability, or Denial Rescission Date is added, this notice must be served on the claimant and his or her attorney or licensed representative, if any, within one business day of the date it is filed electronically with the chair.

**Employee Name** John T Doe

**WCB Case Number (JCN)** G2687881 **Date of Injury** 06/06/2020

**Claim Administrator Claim Number** BRI-26 **Maintenance Type Code Date** 10/14/2020

**Claim Type** P - Indemnity with No Lost Time Beyond Waiting Period **WCB Received Date** 10/14/2020

**Agreement to Compensate** W - Without Liability

**INSURER INFORMATION**

**FEIN** xxxxx6212 **Insurer ID** W212500

**CLAIM ADMINISTRATOR INFORMATION**

**Name** All American Insurance Company **FEIN** xxxxx6212

**Claim Representative Name** Mary Clark **Postal Code** 12202

**Claim Representative Business Phone Number** 5185551212

**E-mail Address** mclark@allamerican.com **Claim Admin ID** W212500

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

**DENIAL REASONS**

**Partial Denial Reason** \_\_\_\_\_

**Partial Denial Effective Date** \_\_\_\_\_

**Full Denial Effective Date** \_\_\_\_\_

**Full Denial Reason** \_\_\_\_\_

**Denial Reason Narrative**

**EMPLOYEE INFORMATION**

**First Name** John **Middle Name/Initial** T

**Last Name** Doe **Suffix** \_\_\_\_\_

**Date of Birth** 09/15/1965

Employee ID Type S - Employee Social Security Number Employee ID xxxxx5544

### CLAIM INFORMATION

Initial Date Employer Had Knowledge of Date of Disability 06/06/2020 Employment Status 1 - Regular/Full-time Employee

Current Date Employer Had Knowledge of Current Date of Disability 06/06/2020 Number of Days Worked Per Week 5

Pre-existing Disability \_\_\_\_\_ Work Week Type S - Standard Work Week

Work Days Scheduled (S-Scheduled N-Non Scheduled) 

S	M	T	W	T	F	S
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

 Wage Period 01 - Weekly

Calculated Wage \$1,200.00 Anticipated Wage Loss \_\_\_\_\_

Calculated Weekly Compensation Amount \$1,000.00 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 - Traumatic Injury Date of Maximum Medical Improvement \_\_\_\_\_

### PERMANENT IMPAIRMENT

Impairment Percentage	Body Part Location	Body Part
10%		11 - Skull

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

### DEPENDENT/PAYEE

Dependent/Payee Relationship	First Name	Last Name	Date of Birth

### WORK STATUS

First Day of Disability After The Waiting Period 06/06/2020

Initial Date Last Day Worked 06/06/2020 Current Date Last Day Worked \_\_\_\_\_

Initial Date Disability Began \_\_\_\_\_ Current Date Disability Began \_\_\_\_\_

Initial RTW Date \_\_\_\_\_ Latest RTW/Status Date \_\_\_\_\_

Initial RTW Type Code \_\_\_\_\_ Latest RTW Type Code \_\_\_\_\_

Initial RTW Physical Restrictions \_\_\_\_\_ Latest RTW Physical Restrictions \_\_\_\_\_

Initial RTW With Same Employer \_\_\_\_\_ Latest RTW With Same Employer \_\_\_\_\_

### SUSPENSION

Suspension Effective Date \_\_\_\_\_ Suspension Reason Code - Full \_\_\_\_\_

## Suspension Reason

## BENEFITS

Reduced Benefit Amount \_\_\_\_\_ Non-Consecutive Period \_\_\_\_\_

Estimated Gross Weekly Amt. \_\_\_\_\_

Overpayment Amount - Current \_\_\_\_\_

Jurisdiction Claim Number - Related \_\_\_\_\_

Acquired Claim Last Known Indemnity Through Date \_\_\_\_\_

Benefit Change Reason Code \_\_\_\_\_

**Benefits**

Benefit Types										
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		
070	07/01/2020	07/31/2020	4	4	07/01/2020	\$1,000.00	07/01/2020	\$1,000.00	07/01/2020	\$1,000.00

**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

## PAYMENTS

Award/Order Date 07/01/2020 Lump Sum Payment/Settlement \_\_\_\_\_

Payment Reasons					
070 - Temporary Partial					
Payment Reason Code	Payee	Start Date	Through Date	Issue Date	Amount Paid
070	John T Doe	07/01/2020	07/31/2020	07/01/2020	\$1,000.00

**Recoveries**

Recovery Type	Amount

**EMPLOYER / INSURED INFORMATION**Employer FEIN xxxxx5777Insured FEIN xxxxx3232**CONCURRENT EMPLOYER INFORMATION**

Name \_\_\_\_\_ Contact Business Phone \_\_\_\_\_ Wage \_\_\_\_\_

**CHANGE DATA ELEMENTS**

Change Data Element/Segment Number	Change Reason Code
0424 - Number of Dependent/Payee Relationships	D - Delete
0066 - Full Wages Paid for Date of Injury Indicator	U - Update
0297 - Initial Date of Lost Time	A - Add