

State of New York - Workers' Compensation Board
Subsequent Report of Injury
Report Type (MTC) AC-Acquisition/Indemnity Ceased

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 who acquired the claim has indicated that indemnity benefits are not being paid and the previous Claim Administrator did not file a suspension notice.

Employee Name John T Doe

WCB Case Number (JCN) G2687883 **Date of Injury** 09/09/2020

Claim Administrator Claim Number BRI-28 **Maintenance Type Code Date** 10/15/2020

Claim Type M - Medical Only **WCB Received Date** 10/15/2020

Agreement to Compensate L - With 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 _____

EMPLOYEE INFORMATION

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

Last Name Doe **Suffix** _____

Date of Birth 09/15/1980

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx5210

CLAIM INFORMATION

Initial Date Employer Had Knowledge of Date of Disability 09/10/2020 Employment Status 1 - Regular/Full-time Employee

Current Date Employer Had Knowledge of Current Date of Disability 09/10/2020 Work Week Type S - Standard Work Week

Work Days Scheduled (S-Scheduled N-Non Scheduled) S M T W T F S Wage Period 01 - Weekly

Calculated Wage \$1,200.00 Anticipated Wage Loss _____

Calculated Weekly Compensation Amount \$1,000.00

Employer Paid Salary Prior To Acquisition _____

Date Claim Administrator Notified of Employee Representation _____

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes

Type of Loss 01 - Traumatic Injury Date of Maximum Medical Improvement _____

PERMANENT IMPAIRMENT

Impairment Percentage	Body Part Location	Body Part

Death Result of Injury _____ Date of Death _____ Number of Dependents _____

WORK STATUS

Initial Date Disability Began 09/10/2020

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 _____

BENEFITS

Reduced Benefit Amount _____

Estimated Gross Weekly Amt. _____

Overpayment Amount - Current _____

Jurisdiction Claim Number - Related _____

Acquired Claim Last Known Indemnity Through Date _____

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		

Other Benefits

Other Benefit Type	Amount

PAYMENTS

Award/Order Date _____

Recoveries

Recovery Type	Amount

EMPLOYER / INSURED INFORMATIONEmployer FEIN xxxxx7766Insured FEIN xxxxx7766**CONCURRENT EMPLOYER INFORMATION**

Name _____ Contact Business Phone _____ Wage _____