

# State of New York - Workers' Compensation Board

## Subsequent Report of Injury

### Report Type (MTC) AP-Acquired/Payment

S7744523

*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 has acquired the claim has begun payment of indemnity benefits and payments are ongoing.

**Employee Name** John T Doe

**WCB Case Number (JCN)** G2687880 **Date of Injury** 05/05/2020

**Claim Administrator Claim Number** BRI-25 **Maintenance Type Code Date** 10/08/2020

**Claim Type** L - Became Indemnity for Lost Time **WCB Received Date** 10/08/2020

**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** 09/15/1966

**Employee ID Type** S - Employee Social Security Number **Employee ID** xxxxx2332

## CLAIM INFORMATION

Initial Date Employer Had Knowledge of Date of Disability 05/05/2020 Employment Status C - Piece Worker

Current Date Employer Had Knowledge of Current Date of Disability \_\_\_\_\_ 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 Denial Rescission Date \_\_\_\_\_

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 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
20%	L - Left	36 - Finger(s) other than thumb

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 \_\_\_\_\_

Initial Date Last Day Worked 05/05/2020 Current Date Last Day Worked \_\_\_\_\_

Initial Date Disability Began 05/05/2020 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 \_\_\_\_\_

### BENEFITS

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

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

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

**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	06/01/2020	06/30/2020	4	1	06/01/2020	\$1,000.00	06/01/2020	\$1,000.00	06/01/2020	\$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 06/01/2020

Payment Reasons					
070 - Temporary Partial					
Payment Reason Code	Payee	Start Date	Through Date	Issue Date	Amount Paid
070	John T Doe	06/01/2020	06/30/2020	06/01/2020	\$1,000.00

**Recoveries**

Recovery Type	Amount

**Reduced Earnings**

Actual Reduced Earnings	Reduced Earnings Week Start Date	Reduced Earnings Week End Date	Reduced Earnings Net Weekly Amount Due By Claim Administrator

**EMPLOYER / INSURED INFORMATION**Employer FEIN xxxxx1212Insured FEIN xxxxx7656**CONCURRENT EMPLOYER INFORMATION**

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