WORKERS' COMPENSATION BOARD

State of New York - Workers' Compensation Board

First Report of Injury
Report Type (MTC) 01-Cancel

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Employee Name John T Doe, Scenario 1-5

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

Claim Administrator Claim Number TW0892356 **Maintenance Type Code Date** 08/10/2012

Insurer FEIN xxxxx6789 **WCB Received Date**

CLAIM ADMINISTRATOR INFORMATION

FEIN xxxxx6789 **State** NY

City Latham **Postal Code** 12110

EMPLOYEE INFORMATION

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

Last Name Doe, Scenario 1-5 **Date of Birth** 11/01/1977

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx6745

EMPLOYER INFORMATION

Employer FEIN xxxxx8765 **Industry Code**

INSURED INFORMATION

Policy Number ID COA65432

Policy Effective Date 01/01/2012 **Policy Expiration Date** 01/01/2013