WORKERS' COMPENSATION BOARD

State of New York - Workers' Compensation Board

First Report of Injury
Report Type (MTC) 02-Change

F20475

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 Denial Reason, 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, Scenario 1-6

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

Claim Administrator Claim Number TW0892356 **Maintenance Type Code Date** 08/25/2012

Claim Type M - Medical Only **WCB Received Date** 09/17/2012

Agreement to Compensate L - With Liability

INSURER INFORMATION

Insurer Name All American Insurance Company **FEIN** xxxxx6789

Insurer Type I - Insurer **Insurer ID** W123456

CLAIM ADMINISTRATOR INFORMATION

Name All American Insurance Company

Info/Attn _____

Address PO Box 12345 _____

City Latham **State** NY

Postal Code 12110 **Country** _____

FEIN xxxxx6789 **Claim Admin ID** T123456

Late Reason _____

FULL DENIAL REASONS

Full Denial Effective Date _____

Full Denial Reason _____

Denial Reason Narrative

_____

EMPLOYEE INFORMATION

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

Last Name Doe, Scenario 1-6 **Suffix**

Mailing Address 123 Nott Street

City Schenectady **State** NY

Postal Code 12308 **Country**

Phone Number 5185550234 **Gender** M - Male

Date of Birth 11/01/1977 **Date of Hire** 04/01/2001

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

Occupation Description Carpenter

CLAIM INFORMATION

Time of injury 13:00 **Date Employer Had Knowledge of the Injury** 08/01/2012

Employment Status 01 - Full Time **Date Claim Administrator Had Knowledge of the Injury** 08/03/2012

Wage Period 01 - Weekly **Date Employer Had Knowledge of Date of Disability** 08/01/2012

Estimated Wage $26.25 **Number of Days Worked Per Week** 5

Work Week Type S - Standard Work Week **Work Days Scheduled** (S-Scheduled N-Non Scheduled)

S	M	T	W	T	F	S
N	S	S	S	S	S	N

Date of Denial Rescission

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes **Employer Paid Salary in Lieu of Compensation** No

Death Result of Injury **Date of Death** **Number of Dependents**

Nature of Injury 49 - Sprain

Part of Body 55 - Ankle

Cause of Injury 26 - Fall, Slip or Trip from ladder

Type of Loss 01 - Trauma

Accident/Injury Description

Mr. Doe was descending a ladder and missed the last step and injured RT ankle

WORK STATUS

Initial Date Last Day Worked **Return To Work Type**

Initial Date Disability Began **Physical Restrictions**

Initial Return to Work Date **Return To Work Same Employer**

ACCIDENT LOCATION AND WITNESSES

Premises E - Employer

Organization Name

Street 1234 Broadway **State** NY

City Albany **Postal Code** 12204

County/Parish Albany **Country**

Location Narrative

Witnesses	Business Phone Number
Jane Smith	5184029394

MEDICAL TREATMENT

Initial Treatment 2 - Minor Clinic/Hospital

Managed Care Org.

Managed Care Org. ID

EMPLOYER INFORMATION

Name Great Roofing Inc. **Employer FEIN** xxxxx8765

Industry Code 236116 **UI Number** 16-10000

Manual Classification 5645 - Carpentry

Info/Attn

Mailing Address PO Box 1587

City Albany **State** NY

Postal Code 12241 **Country**

Physical Addr 1541 Circular St.

City Albany **State** NY

Postal Code 12241 **Country**

Contact Name Jane Smith

Contact Business Phone Number 5184029394

INSURED INFORMATION

Insured Name Great Roofing Inc.

Insured FEIN xxxxx8765

Insured Type I - Insured

Insured Location ID JS51

Policy Number ID COA65432

Policy Effective Date 01/01/2012

Policy Expiration Date 01/01/2013