WORKERS' COMPENSATION BOARD

F20475

State of New York - Workers' Compensation Board

First Report of Injury
Report Type (MTC) UR-Upon Request

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

Employee Name John T Doe, Scenario 9-4

WCB Case Number (JCN) 50009999

Date of Injury 02/02/2004

Claim Administrator Claim Number TW0892356

Maintenance Type Code Date 11/19/2012

Claim Type I - Indemnity

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

SAMPLE

EMPLOYEE INFORMATION

First Name	John	**Middle Name/Initial**	T
Last Name	Doe, Scenario 9-4	**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**	02/02/2004
Employment Status	01 - Full Time	**Date Claim Administrator Had Knowledge of the Injury**	02/02/2004
Wage Period	01 - Weekly	**Date Employer Had Knowledge of Date of Disability**	02/02/2004
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 28 - Fracture

Part of Body 42 - Low Back Area

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

Type of Loss 01 - Trauma

Accident/Injury Description

Mr. Doe was stepping off a roof and lost his footing and fell from a ladder injuring his back

WORK STATUS

Initial Date Last Day Worked	02/03/2004	**Return To Work Type**	
Initial Date Disability Began		**Physical Restrictions**	
Initial Return to Work Date		**Return To Work Same Employer**	

SAMPLE

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 3 - Emergency Room

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

SAMPLE

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	01/01/2004	**Policy Expiration Date**	01/01/2005

SAMPLE