State of New York - Workers' Compensation Board

Subsequent Report of Injury
Report Type (MTC) AP-Acquired/Payment

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 DOE Scenario 9-5

WCB Case Number (JCN) 50009999 **Date of Injury** 02/02/2004

Claim Administrator Claim Number A678B1234 **Maintenance Type Code Date** 11/19/2012

Claim Type I - Indemnity for Lost Time **WCB Received Date** 02/01/2013

Agreement to Compensate L - With Liability

INSURER INFORMATION

FEIN xxxxx6789 **Insurer ID** W123456

CLAIM ADMINISTRATOR INFORMATION

Name GREAT LAKES CLAIMS **FEIN** xxxxx9145

Claim Representative Name MAX SMITH **Postal Code** 48201

Business Phone Number 8007850024 **Fax Number** 8007855025

E-mail Address msmith@greatlakesclaims.com **Claim Admin ID** W123456

Late Reason

EMPLOYEE INFORMATION

First Name JOHN **Middle Name/Initial**

Last Name DOE Scenario 9-5 **Suffix**

Date of Birth 11/01/1977

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

CLAIM INFORMATION

Date Employer Had Knowledge of Date of Disability 02/02/2004

Pre-existing Disability No

Work Days Scheduled (S-Scheduled N-Non Scheduled)

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

Calculated Wage $600.00

Calculated Weekly Compensation Amount $400.00

Employer Paid Salary Prior To Acquisition

Date Claim Administrator Notified of Employee Representation

Employment Status 1 - Full Time

Number of Days Worked Per Week 5

Work Week Type S - Standard Work Week

Wage Period 01 - Weekly

Denial Rescission Date

SAMPLE

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes

Employer Paid Salary in Lieu of Compensation No

Type of Loss 01 - Trauma

Date of Maximum Medical Improvement

PERMANENT IMPAIRMENT

Impairment Percentage 50.0%

Body Part 42 - Low Back

Death Result of Injury

Date of Death

Number of Dependents

Dependent/Payee Relationship

WORK STATUS

First Day of Disability After The Waiting Period 02/03/2004

Current Date Last Day Worked

Initial Date Last Day Worked 02/02/2004

Current Date Disability Began

Initial Date Disability Began 02/03/2004

Latest Return to Work Status Date

Initial Return to Work Date

Return To Work Type

Physical Restrictions

Return To Work Same Employer

BENEFITS

Reduced Benefit Amount

Non-Consecutive Period

Estimated Gross Weekly Amt.

Benefits

Benefit Types											
030 - Permanent Partial											
Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross Effective Date	Weekly Gross Amount	Weekly Net Effective Date	Weekly Net Amount	Benefit Payment Issue Date	Amount Paid	
030	11/15/2012	11/21/2012	0001	0	08/19/2006	$200.00	08/19/2006	$200.00	11/21/2012	$200.00	

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	Other Benefit Type	Amount
430 - Total Unallocated Prior Indemnity Benefits	$97,400.00	440 - Total Unallocated Prior Medical	$49,561.30

SAMPLE

PAYMENTS

Award/Order Date _____

Payment Reasons					
030 - Permanent Partial					
Payment Reason Code	Payee	Start Date	Through Date	Issue Date	Amount Paid
030	John Doe	11/15/2012	11/21/2012	11/21/2012	$200.00

Recoveries

Recovery Type	Amount

Reduced Earnings

Week Number	Actual Reduced Earnings

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx8765 **Insured FEIN** xxxxx8765

CONCURRENT EMPLOYER INFORMATION

Name _____ **Contact Business Phone** _____ **Wage** _____

SAMPLE