WORKERS' COMPENSATION BOARD

S20085

State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) CB-Change in Benefit Type

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 has changed the benefit type from what was previously reported.

Employee Name JOHN DOE Scenario 2.5

WCB Case Number (JCN) G0055555

Date of Injury 08/01/2012

Claim Administrator Claim Number TW0892356

Maintenance Type Code Date 09/19/2012

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 ALL AMERICAN INSURANCE COMPANY

FEIN xxxxx6789

Claim Representative Name MARY CLARK

Postal Code 12110

Business Phone Number 5187855000

Fax Number 5187855001

E-mail Address mclark@allamerican.com

Claim Admin ID W123456

Late Reason

EMPLOYEE INFORMATION

First Name JOHN

Middle Name/Initial

Last Name DOE Scenario 2.5

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 08/01/2012

Employment Status 1 - Full Time

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

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

Work Week Type S - Standard Work Week

Calculated Wage $1,050.00

Wage Period 01 - Weekly

Calculated Weekly Compensation Amount $700.00

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 - Trauma

Date of Maximum Medical Improvement ____________

PERMANENT IMPAIRMENT

Impairment Percentage __________ **Body Part** ____________________

Number of Dependents ______

Dependent/Payee Relationship ____________________

WORK STATUS

First Day of Disability After The Waiting Period 08/02/2012

Current Date Last Day Worked ____________

Initial Return to Work Date ____________

Current Date Disability Began ____________

Latest Return to Work Status 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
050 - Temporary Total
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		
050	08/02/2012	09/04/2012	4	4	08/02/2012	$700.00	08/02/2012	$700.00		$3,360.00
070	09/05/2012	09/19/2012	2	1	09/05/2012	$350.00	09/05/2012	$350.00	09/19/2012	$770.00

Benefits - A - Adjustments / C - Credits / R - Redistributions

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount
070 - Temporary Partial	C	C - Overpayment Credit	09/05/2012	09/19/2012	$350.00

Other Benefits

Other Benefit Type	Amount

PAYMENTS

Award/Order Date ____________

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 ____________