State of New York - Workers' Compensation Board

Subsequent Report of Injury
Report Type (MTC) CD-Compensable Death

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

No benefits are being paid at this time pending further Beneficiary investigation.

Employee Name JOHN DOE Scenario 4-2

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

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

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 4-2 **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

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 $1,050.00

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

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes

Type of Loss 01 - Trauma **Date of Maximum Medical Improvement**

Death Result of Injury Yes **Date of Death** 08/01/2012

WORK STATUS

Initial Date Disability Began 08/02/2012

BENEFITS

Reduced Benefit Amount

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

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx8765 **Insured FEIN** xxxxx8765

CONCURRENT EMPLOYER INFORMATION

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