State of New York - Workers' Compensation Board

Subsequent Report of Injury
Report Type (MTC) ER-Employer Reinstatement

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

Employer has resumed paying the injured employee's salary in lieu of compensation. The Claim Administrator is not paying indemnity benefits at this time.

Employee Name John J Smith Jr

WCB Case Number (JCN) 06152001 **Date of Injury** 06/15/2001

Claim Administrator Claim Number WC1256782 **Maintenance Type Code Date** 08/07/2001

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

Agreement to Compensate

INSURER INFORMATION

FEIN xxxxx2378 **Insurer ID** W123456

CLAIM ADMINISTRATOR INFORMATION

Name Old Reliable Insurance Company **FEIN** xxxxx2378

Claim Representative Name **Postal Code** 37992-1223

Business Phone Number 8505551957 **Fax Number**

E-mail Address **Claim Admin ID** W123456

Late Reason

EMPLOYEE INFORMATION

First Name John **Middle Name/Initial** J

Last Name Smith **Suffix** Jr

Date of Birth 05/01/1953

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

CLAIM INFORMATION

Date Employer Had Knowledge of Date of Disability

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

Work Week Type S - Standard Work Week

Wage Period 01- Weekly

Denial Rescission Date

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes

Employer Paid Salary in Lieu of Compensation Yes

Type of Loss 01 - Trauma

Date of Maximum Medical Improvement

PERMANENT IMPAIRMENT

Impairment Percentage

Body Part

Death Result of Injury

Number of Dependents 00

Dependent/Payee Relationship

WORK STATUS

First Day of Disability After The Waiting Period

Current Date Last Day Worked 07/31/2001

Initial Return to Work Date 07/12/2001

Current Date Disability Began 08/01/2001

Latest Return to Work Status Date

Return To Work Type

Physical Restrictions

Return To Work Same Employer Yes

BENEFITS

Reduced Benefit Amount

Non-Consecutive Period

Benefits

Benefit Types										
240 - Employer Paid (EP) Unspecified										
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
240	08/01/2001	08/07/2001								

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

PAYMENTS

Award/Order Date

Recoveries

Recovery Type	Amount

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx4235 **Insured FEIN** xxxxx4235

CONCURRENT EMPLOYER INFORMATION

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