WORKERS' COMPENSATION BOARD

State of New York - Workers' Compensation Board

Subsequent Report of Injury
Report Type (MTC) PY-Payment Report

S20085

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 made payment(s) as reflected in Benefits and/or Payments Section of this document.

Employee Name JOHN DOE Scenario 7-2

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

Claim Administrator Claim Number TW0892356 **Maintenance Type Code Date** 01/03/2013

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 7-2 **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

Calculated Weekly Compensation Amount $700.00

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

Employer Paid Salary in Lieu of Compensation No

Type of Loss 01 - Trauma

Date of Maximum Medical Improvement

PERMANENT IMPAIRMENT

Impairment Percentage

Body Part

Death Result of Injury

Date of Death

Number of Dependents

Dependent/Payee Relationship

WORK STATUS

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

Latest Return to Work Status Date

Initial Date Disability Began 08/02/2012

Initial Return to Work Date

Return To Work Type

Physical Restrictions

Return To Work Same Employer

BENEFITS

Reduced Benefit Amount

Estimated Gross Weekly Amt.

Benefits

Benefit Types
500 - Unspecified Lump Sum Payment/Settlement

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
500	01/03/2013	01/03/2013								$18,000.00

Benefits - Cumulative

Benefit Type	Start Date	Through Date	Claim Weeks	Claim Days	Amount Paid
050 - Temporary Total	08/02/2012	12/14/2012	19	2	$13,340.00

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
340 - Total Claimant's Legal Expense	$2,000.00

PAYMENTS

Award/Order Date 12/31/2012 **Lump Sum Payment/Settlement** SF - Settlement Full

Payment Reasons
500 - Unspecified Lump Sum Payment/Settlement
340 - Total Claimant's Legal Expense

Payment Reason Code	Payee	Start Date	Through Date	Issue Date	Amount Paid
500	John Doe	01/03/2013	01/03/2013	01/03/2013	$18,000.00
340	Attorney Doe	01/03/2013	01/03/2013	01/03/2013	$2,000.00

Recoveries

Recovery Type	Amount

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx8765 **Insured FEIN** xxxxx8765

CONCURRENT EMPLOYER INFORMATION

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