WORKERS' COMPENSATION BOARD

S20085

State of New York - Workers' Compensation Board
Subsequent Report of Injury
Report Type (MTC) RE-Reduced Earnings

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 adjusted the rate due to claimant's return to work with restrictions and wages are less than pre-injury wages.

Employee Name JOHN DOE Scenario 2-6

WCB Case Number (JCN) G0055555

Date of Injury 08/01/2012

Claim Administrator Claim Number TW0892356

Maintenance Type Code Date 10/22/2012

Claim Type I - Indemnity

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 2-6

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

Number of Days Worked Per Week 5

Calculated Wage $1,050.00

Work Week Type S - Standard Work Week

Calculated Weekly Compensation Amount $700.00

Wage Period 01 - Weekly

Employer Paid Salary Prior To Acquisition

Date Claim Administrator Notified of Employee Representation

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 __________ **Body Part** ____________________

WORK STATUS

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

Current Date Disability Began ____________

Initial Date Disability Began 08/02/2012

Initial Return to Work Date 10/08/2012

Return To Work Type A - Actual **Physical Restrictions** Yes **Return To Work Same Employer** Yes

BENEFITS

Reduced Benefit Amount ____________________

Estimated Gross Weekly Amt. ________

Benefits

Benefit Types

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		
070	09/05/2012	10/19/2012	6	3	10/08/2012	$366.67	10/08/2012	$366.67	10/22/2012	$2,343.34

Benefits - Cumulative

Benefit Type	Start Date	Through Date	Claim Weeks	Claim Days	Amount Paid
050 - Temporary Total	08/02/2012	09/04/2012	4	4	$3,360.00

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

PAYMENTS

Award/Order Date ____________

SAMPLE

Recoveries

Recovery Type	Amount

Reduced Earnings

Week Number	Actual Reduced Earnings	Week Number	Actual Reduced Earnings
1	$366.67	2	$366.67

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx8765 **Insured FEIN** xxxxx8765

CONCURRENT EMPLOYER INFORMATION

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