WORKERS' COMPENSATION BOARD

S20085

State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) S7-Suspension, Benefits Exhausted

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 suspended indemnity benefits for the reasons reflected in the Suspension Section of this document.

Employee Name JOHN DOE Scenario 8-3

WCB Case Number (JCN) G0055555

Date of Injury 08/01/2012

Claim Administrator Claim Number TW0892356

Maintenance Type Code Date 05/22/2018

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 8-3

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

SAMPLE

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes

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

PERMANENT IMPAIRMENT

Impairment Percentage 50.0% **Body Part** 54 - Lower Leg

Death Result of Injury **Number of Dependents**

Dependent/Payee Relationship

WORK STATUS

Initial Date Disability Began 08/02/2012

Initial Return to Work Date

Return To Work Type **Physical Restrictions** **Return To Work Same Employer** Yes

SUSPENSION

Suspension Effective Date 05/22/2018

Suspension Reason

Clt reached cap on PPD benefits. Clt classified 50PPD per 08/15/12 hearing, CAP/Max of 300 weeks.

BENEFITS

Reduced Benefit Amount

Estimated Gross Weekly Amt.

Benefits

Benefit Types

030 - Permanent Partial Scheduled

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
030	08/15/2012	05/15/2018	300		08/15/2012	$350.00	08/15/2012	$350.00	05/22/2018	$105,000.00

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
070 - Temporary Partial	09/05/2010	08/14/2012	101	2	$35,490.00

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

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount

SAMPLE

Other Benefits

Other Benefit Type	Amount

PAYMENTS

Award/Order Date 08/20/2012

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** ______

SAMPLE