State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) SA-Sub-Annual

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

Employee Name JOHN DOE Scenario 9-1

WCB Case Number (JCN) G0055555

Date of Injury 08/01/2012

Claim Administrator Claim Number TW0892356

Maintenance Type Code Date 02/01/2013

WCB Received Date 02/01/2013

Agreement to Compensate

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

EMPLOYEE INFORMATION

First Name JOHN

Middle Name/Initial

Last Name DOE Scenario 9-1

Suffix

Date of Birth 11/01/1977

Employee ID Type S - Employee Social Security Number

Employee ID xxxxx6745

BENEFITS

Benefits

Benefit Types

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		

Benefits - Cumulative

Benefit Type	Start Date	Through Date	Claim Weeks	Claim Days	Amount Paid
050 - Temporary Total	08/02/2012	09/04/2012	0004	4	$3,360.00

Benefit Type	Start Date	Through Date	Claim Weeks	Claim Days	Amount Paid
070 - Temporary Partial	09/05/2012	02/01/2013	0021	3	$7,560.00

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	Other Benefit Type	Amount
350 - Total Payment to Physicians	$1,560.00	360 - Total Hospital Costs	$2,120.00
450 - Total Pharmaceutical Costs	$356.00		

Recoveries

Recovery Type	Amount

CONCURRENT EMPLOYER INFORMATION

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