Workers' Compensation Board

State of New York - Workers' Compensation Board

First Report of Injury
Report Type (MTC) 01-Cancel Entire Claim

F5097850

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Employee Name Jane Smith

WCB Case Number (JCN) G2687884 **Date of Injury** 02/02/2020

Claim Administrator Claim Number BRI-29 **Maintenance Type Code Date** 10/15/2020

Insurer FEIN xxxxx6212 **WCB Received Date** 10/15/2020

CLAIM ADMINISTRATOR INFORMATION

FEIN xxxxx6212 **State** NY

City Albany **Postal Code** 12202

EMPLOYEE INFORMATION

First Name Jane **Middle Name/Initial**

Last Name Smith **Date of Birth** 09/15/1981

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx1212

EMPLOYER INFORMATION

Employer FEIN xxxxx5255 **Industry Code** 812910

INSURED INFORMATION

Policy Number ID

Policy Effective Date 01/01/2020 **Policy Expiration Date**

CANCELLATION REASON

Cancel Reason Code J - Jurisdiction Wrong/Changed **JCN - Related**

Cancel Reason Narrative

Cancelling this for a good reason.