Workers' Compensation Board

F5098457

State of New York - Workers' Compensation Board

First Report of Injury

Report Type (MTC) UR-Upon Request (Grandfathered)

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Employee Name Randall Smith

WCB Case Number (JCN) 00001308

Date of Injury 11/17/1999

Claim Administrator Claim Number N042-99-73218

Maintenance Type Code Date 01/09/2021

Claim Type M - Medical Only

WCB Received Date 01/20/2021

Agreement to Compensate L - With Liability

INSURER INFORMATION

Insurer Name All American Insurance Company

FEIN xxxxx4504

Insurer Type I - Insurer

Insurer ID W804504

CLAIM ADMINISTRATOR INFORMATION

Name All American Insurance Company

Info/Attn John T Doe

Address 12 State St

City Rensselaer

State NY

Postal Code 12144-9315

Country US - UNITED STATES

FEIN xxxxx4504

Claim Admin ID W804504

Late Reason

Claim Representative Name John T Doe

Claim Representative Business Phone Number 5185551212

Claim Representative E-mail Address jdoe@allamerican.com

FULL DENIAL REASONS

Full Denial Reason

Denial Reason Narrative

EMPLOYEE INFORMATION

First Name Randall
Middle Name/Initial
Last Name Smith
Suffix
Mailing Address 29 Park Place
City Albany
State NY
Postal Code 12202
Country US - UNITED STATES
Phone Number 5186542323
Gender M - Male
Date of Birth 02/01/1980
Date of Hire 09/01/1999
Employee ID Type S - Employee Social Security Number
Employee ID xxxxx5298
Occupation Description

CLAIM INFORMATION

Time of injury 10:10
Date Employer Had Knowledge of the Injury 11/17/1999
Employment Status 1 - Regular/Full-time Employee
Date Claim Administrator Had Knowledge of the Injury 11/17/1999
Wage Period 01 - Weekly
Initial Date Employer Had Knowledge of Date of Disability 11/17/1999
Estimated Wage $125,000.00
Current Date Employer had Knowledge of Current Date of Disability
Work Week Type S - Standard Work Week
Number of Days Worked Per Week 5
Date of Denial Rescission
Work Days Scheduled (S-Scheduled N-Non Scheduled)

S	M	T	W	T	F	S

EMPLOYEE INJURY

Full Wages Paid for Date of Injury No
Employer Paid Salary in Lieu of Compensation No
Death Result of Injury
Date of Death
Number of Dependents 0
Nature of Injury 28 - Fracture

Part of Body

Part of Body Injured Location	Part of Body Injured	Part of Body Injured Fingers/Toes Location
R - Right	35 - Hand	

Cause of Injury 29 - Fall, Slip or Trip Injury - On Same Level
Type of Loss 01 - Traumatic Injury
Accident/Injury Description

Slipped and broke ankle

WORK STATUS

Initial Date Last Day Worked	11/17/1999	**Initial RTW Type Code**	
Initial Date Disability Began	11/17/1999	**Initial RTW Physical Restrictions**	
Initial RTW Date		**Initial RTW With Same Employer**	
Latest RTW Type Code		**Latest RTW Physical Restrictions**	
Latest RTW/Status Date		**Latest RTW With Same Employer**	
Current Date Disability Began		**Current Date Last Day Worked**	
		First Day of Disability After the Waiting Period	

ACCIDENT LOCATION AND WITNESSES

Premises	E - Employer		
Organization Name	Mels Diner		
Street	1976 Broadway	**State**	NY
City	Albany	**Postal Code**	12144
County/Parish	Albany - Albany	**Country**	US - UNITED STATES
Location Narrative	Restaurant		

Witnesses	**Business Phone Number**

MEDICAL TREATMENT

Initial Treatment	1 - Minor On-Site Remedies by Employer
Managed Care Org.	
Managed Care Org. ID	

EMPLOYER INFORMATION

Name Mel Smith

Employer FEIN xxxxx5256

Industry Code 812910

UI Number

Manual Classification 9079 - Restaurants

Info/Attn

Mailing Address 1976 Broadway

City Albany

State NY

Postal Code 12202

Country US - UNITED STATES

Physical Addr 1976 Broadway

City Rensselaer

State NY

Postal Code 12144-9315

Country US - UNITED STATES

Contact Name

Contact Business Phone Number

INSURED INFORMATION

Insured Name Mels Diner

Insured FEIN xxxxx2533

Insured Type S - Self-Insured

Insured Location ID

Policy Number ID

Policy Effective Date 01/01/1999

Policy Expiration Date 12/31/1999