This form only displays data that has been changed on this 02 transaction.
Please view FROI/SROI in eCase for the most current data listed on this case file.

Workers' Compensation Board

State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) 02-Change

S10419741

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

Pursuant to 12 NYCRR § 300.22, when the claim administrator is changing the Agreement to Compensate Code from Without Liability to With Liability, or Denial Rescission Date is added, this notice must be served on the claimant and his or her attorney or licensed representative, if any, within one business day of the date it is filed electronically with the chair.

Employee Name John Doe

WCB Case Number (JCN) G3113423 **Date of Injury** 12/21/2007

Claim Administrator Claim Number TEST12232101 **Maintenance Type Code Date** 05/20/2024

Claim Type **WCB Received Date** 05/20/2024

Agreement to Compensate

INSURER INFORMATION

FEIN xxxxx9999 **Insurer ID** W999999

CLAIM ADMINISTRATOR INFORMATION

Name **FEIN** xxxxx9999

Claim Representative Name **Postal Code**

Claim Representative Business Phone Number

E-mail Address **Claim Admin ID** W999999

Late Reason

DENIAL REASONS

Partial Denial Reason

Partial Denial Effective Date

Full Denial Effective Date

Full Denial Reason

Denial Reason Narrative

EMPLOYEE INFORMATION

First Name John **Middle Name/Initial**

Last Name Doe **Suffix**

Date of Birth 11/01/1977

Employee ID Type A - Employee ID Assigned by Jurisdiction **Employee ID** 771101MMOUSE

CLAIM INFORMATION

Initial Date Employer Had Knowledge of Date of Disability _____ **Employment Status** _____

Current Date Employer Had Knowledge of Current Date of Disability _____ **Number of Days Worked Per Week** _____

Pre-existing Disability _____ **Work Week Type** _____

Work Days Scheduled (S-Scheduled N-Non Scheduled) S M T W T F S [ ][ ][ ][ ][ ][ ][ ] **Wage Period** _____

Calculated Wage _____ **Anticipated Wage Loss** _____

Calculated Weekly Compensation Amount _____ **Denial Rescission Date** _____

Employer Paid Salary Prior To Acquisition _____

Date Claim Administrator Notified of Employee Representation _____

EMPLOYEE INJURY

Full Wages Paid for Date of Injury _____ **Employer Paid Salary in Lieu of Compensation** _____

Type of Loss _____ **Date of Maximum Medical Improvement** _____

PERMANENT IMPAIRMENT

Impairment Percentage	Body Part Location	Body Part

Death Result of Injury _____ **Date of Death** _____ **Number of Dependents** _____

DEPENDENT/PAYEE

Dependent/Payee Relationship	First Name	Last Name	Date of Birth

WORK STATUS

First Day of Disability After The Waiting Period _____

Initial Date Last Day Worked _____ **Current Date Last Day Worked** _____

Initial Date Disability Began _____ **Current Date Disability Began** _____

Initial RTW Date _____ **Latest RTW/Status Date** _____

Initial RTW Type Code _____ **Latest RTW Type Code** _____

Initial RTW Physical Restrictions _____ **Latest RTW Physical Restrictions** _____

Initial RTW With Same Employer _____ **Latest RTW With Same Employer** _____

SUSPENSION

Suspension Effective Date _____ **Suspension Reason Code - Full** _____

Suspension Reason

BENEFITS

Reduced Benefit Amount _____ **Non-Consecutive Period** _____

Estimated Gross Weekly Amt. _____

Overpayment Amount - Current _____

Jurisdiction Claim Number - Related _____

Acquired Claim Last Known Indemnity Through Date _____

Benefit Change Reason Code _____

Net to Zero Code _____

Benefits

Benefit Types										
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

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 _____ **Lump Sum Payment/Settlement** _____

Payment Reasons					
Payment Reason Code	Payee	Start Date	Through Date	Issue Date	Amount Paid

Recoveries

Recovery Type	Amount

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx4234 **Insured FEIN**

CONCURRENT EMPLOYER INFORMATION

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

CHANGE DATA ELEMENTS

Change Data Element/Segment Number	Change Reason Code
0043 - Employee Last Name	U - Update
0044 - Employee First Name	U - Update