Workers' Compensation Board

State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) AC-Acquisition/Indemnity Ceased

S7744542

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 who acquired the claim has indicated that indemnity benefits are not being paid and the previous Claim Administrator did not file a suspension notice.

Employee Name John T Doe

WCB Case Number (JCN) G2687883 **Date of Injury** 09/09/2020

Claim Administrator Claim Number BRI-28 **Maintenance Type Code Date** 10/15/2020

Claim Type M - Medical Only **WCB Received Date** 10/15/2020

Agreement to Compensate L - With Liability

INSURER INFORMATION

FEIN xxxxx6212 **Insurer ID** W212500

CLAIM ADMINISTRATOR INFORMATION

Name All American Insurance Company **FEIN** xxxxx6212

Claim Representative Name Mary Clark **Postal Code** 12202

Claim Representative Business Phone Number 5185551212

E-mail Address mclark@allamerican.com **Claim Admin ID** W212500

Late Reason

EMPLOYEE INFORMATION

First Name John **Middle Name/Initial** T

Last Name Doe **Suffix**

Date of Birth 09/15/1980

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx5210

CLAIM INFORMATION

Initial Date Employer Had Knowledge of Date of Disability 09/10/2020

Current Date Employer Had Knowledge of Current Date of Disability 09/10/2020

Work Days Scheduled (S-Scheduled N-Non Scheduled) S M T W T F S

Calculated Wage $1,200.00

Calculated Weekly Compensation Amount $1,000.00

Employer Paid Salary Prior To Acquisition

Date Claim Administrator Notified of Employee Representation

Employment Status 1 - Regular/Full-time Employee

Work Week Type S - Standard Work Week

Wage Period 01 - Weekly

Anticipated Wage Loss

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes

Type of Loss 01 - Traumatic Injury

Date of Maximum Medical Improvement

PERMANENT IMPAIRMENT

Impairment Percentage	Body Part Location	Body Part

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

WORK STATUS

Initial Date Disability Began 09/10/2020

Initial RTW Date

Initial RTW Type Code

Initial RTW Physical Restrictions

Initial RTW With Same Employer

Latest RTW/Status Date

Latest RTW Type Code

Latest RTW Physical Restrictions

Latest RTW With Same Employer

BENEFITS

Reduced Benefit Amount

Estimated Gross Weekly Amt.

Overpayment Amount - Current

Jurisdiction Claim Number - Related

Acquired Claim Last Known Indemnity Through Date

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

Other Benefits

Other Benefit Type	Amount

PAYMENTS

Award/Order Date _____

Recoveries

Recovery Type	Amount

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx7766 **Insured FEIN** xxxxx7766

CONCURRENT EMPLOYER INFORMATION

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