

State of New York - Workers' Compensation Board
Subsequent Report of Injury
Report Type (MTC) AP-Acquired/Payment

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 has acquired the claim has begun payment of indemnity benefits and payments are ongoing.

Employee Name John T Doe

WCB Case Number (JCN) G2687881 **Date of Injury** 06/06/2020

Claim Administrator Claim Number BRI-26 **Maintenance Type Code Date** 10/08/2020

Claim Type P - Indemnity with No Lost Time Beyond Waiting Period **WCB Received Date** 10/08/2020

Agreement to Compensate W - Without 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 09/15/1965

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx5544

CLAIM INFORMATION

Initial Date Employer Had Knowledge of Date of Disability 06/06/2020 Employment Status 1 - Regular/Full-time Employee
 Current Date Employer Had Knowledge of Current Date of Disability 06/06/2020 Number of Days Worked Per Week 5
 Pre-existing Disability _____ Work Week Type S - Standard Work Week
 Work Days Scheduled (S-Scheduled N-Non Scheduled)

| | | | | | | |
|---|---|---|---|---|---|---|
| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|

 Wage Period 01 - Weekly
 Calculated Wage \$1,200.00 Denial Rescission Date _____
 Calculated Weekly Compensation Amount \$1,000.00
 Employer Paid Salary Prior To Acquisition _____
 Date Claim Administrator Notified of Employee Representation _____

EMPLOYEE INJURY

Full Wages Paid for Date of Injury No Employer Paid Salary in Lieu of Compensation No
 Type of Loss 01 - Traumatic Injury Date of Maximum Medical Improvement _____

PERMANENT IMPAIRMENT

| Impairment Percentage | Body Part Location | Body Part |
|-----------------------|--------------------|------------|
| 10% | | 11 - Skull |

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

DEPENDENT/PAYEE

| Dependent/Payee Relationship | First Name | Last Name | Date of Birth |
|-----------------------------------|------------|-----------|---------------|
| 41 - Son/Daughter (birth order 1) | Judy | Jetson | 02/02/2000 |

WORK STATUS

First Day of Disability After The Waiting Period _____
 Initial Date Last Day Worked 06/06/2020 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 _____

BENEFITS

Reduced Benefit Amount _____ Non-Consecutive Period _____
 Estimated Gross Weekly Amt. _____
 Overpayment Amount - Current _____

Benefits

| Benefit Types | | | | | | | | | | |
|-------------------------|------------|--------------|-------------|------------|----------------|------------|----------------|------------|----------------------------|-------------|
| 070 - Temporary Partial | | | | | | | | | | |
| 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 | | |
| 070 | 07/01/2020 | 07/31/2020 | 4 | 4 | 07/01/2020 | \$1,000.00 | 07/01/2020 | \$1,000.00 | 07/01/2020 | \$1,000.00 |

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 |
|--------------------|--------|
| | |

PAYMENTSAward/Order Date 07/01/2020

| Payment Reasons | | | | | | |
|-------------------------|------------|------------|--------------|------------|-------------|--|
| 070 - Temporary Partial | | | | | | |
| Payment Reason Code | Payee | Start Date | Through Date | Issue Date | Amount Paid | |
| 070 | John T Doe | 07/01/2020 | 07/31/2020 | 07/01/2020 | \$1,000.00 | |

Recoveries

| Recovery Type | Amount |
|---------------|--------|
| | |

Reduced Earnings

| Actual Reduced Earnings | Reduced Earnings Week Start Date | Reduced Earnings Week End Date | Reduced Earnings Net Weekly Amount Due By Claim Administrator |
|-------------------------|----------------------------------|--------------------------------|---|
| | | | |

EMPLOYER / INSURED INFORMATIONEmployer FEIN xxxxx5777Insured FEIN xxxxx3232**CONCURRENT EMPLOYER INFORMATION**

Name _____ Contact Business Phone _____ Wage _____

TO THE CLAIMANT

Your employer or its insurance carrier has started to make payments without prejudice for the accident which occurred on the date shown below. Under this program, an employer or its insurance carrier begins making payments to you in order to provide you with temporary funds, while still investigating the circumstances of the reported accident or injury, including an investigation as to whether it is the correct insurance carrier. You should have received a notice from the employer or carrier indicating that payments have begun. The reason that you are receiving payments should be identified on the notice you received from the employer or insurance carrier. Contact your employer or its insurance carrier, if you have not received this notice. If you have not started to receive payments, contact the nearest office of the Workers' Compensation Board immediately.

If the employer or insurance carrier is still investigating the circumstances of the reported accident or injury, payments are made pursuant to Workers' Compensation Law 21-a. **The payment of temporary compensation is not an admission by the employer that it is liable for your injury or injuries.** Your acceptance of temporary payments will not prejudice your claim for further benefits. Your employer may request that you enter into an agreement in order to ensure the continuation of payments of temporary compensation. Temporary compensation and prescribed medical payments may continue for up to one year from the date of first payment, or until your employer contests your right to compensation, or until the Board's determination of your claim, whichever is first. Your employer may stop temporary payments at any time provided it sends you a notice of termination of temporary payments within five days after the last payment is made. If your employer stops temporary payments, it will notify you in writing whether or not it is contesting your claim. (Contact the Board immediately if your payments stop and you do not receive a written notice from the employer.) The Board will then notify you of any further action taken in your case. If your employer does not send you a notice of termination of temporary benefits within one year after the start of payments, your employer will be considered to have admitted liability for your claim.