

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) G2687880 **Date of Injury** 05/05/2020

Claim Administrator Claim Number BRI-25 **Maintenance Type Code Date** 10/08/2020

Claim Type L - Became Indemnity for Lost Time **WCB Received Date** 10/08/2020

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 09/15/1966

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx2332

CLAIM INFORMATION

Initial Date Employer Had Knowledge of Date of Disability 05/05/2020 Employment Status C - Piece Worker

Current Date Employer Had Knowledge of Current Date of Disability _____ 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
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 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 Yes 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
20%	L - Left	36 - Finger(s) other than thumb

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 05/05/2020 Current Date Last Day Worked _____

Initial Date Disability Began 05/05/2020 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	06/01/2020	06/30/2020	4	1	06/01/2020	\$1,000.00	06/01/2020	\$1,000.00	06/01/2020	\$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 06/01/2020

Payment Reasons						
070 - Temporary Partial						
Payment Reason Code	Payee	Start Date	Through Date	Issue Date	Amount Paid	
070	John T Doe	06/01/2020	06/30/2020	06/01/2020	\$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 xxxxx1212Insured FEIN xxxxx7656**CONCURRENT EMPLOYER INFORMATION**

Name _____ Contact Business Phone _____ Wage _____