

State of New York - Workers' Compensation Board
Subsequent Report of Injury
Report Type (MTC) CA-Change in Benefit Amount

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 has changed the net weekly amount from what was previously reported, but the benefit type has not changed.

Employee Name John T Doe

WCB Case Number (JCN) G2687906 **Date of Injury** 10/01/2020

Claim Administrator Claim Number VPAL126 **Maintenance Type Code Date** 12/29/2020

Claim Type I - Indemnity for Lost Time **WCB Received Date** 12/29/2020

Agreement to Compensate L - With Liability

INSURER INFORMATION

FEIN xxxxx6266 **Insurer ID** W010698

CLAIM ADMINISTRATOR INFORMATION

Name All American Insurance Company **FEIN** xxxxx6266

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

Claim Representative Business Phone Number 5185185181

E-mail Address mclark@allamerican.com **Claim Admin ID** W010698

Late Reason _____

EMPLOYEE INFORMATION

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

Last Name Doe **Suffix** _____

Date of Birth 08/19/1987

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx5432

CLAIM INFORMATION

Initial Date Employer Had Knowledge of Date of Disability 10/01/2020 Employment Status 1 - Regular/Full-time Employee
 Current Date Employer Had Knowledge of Current Date of Disability 10/01/2020 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 \$4,000.00
 Calculated Weekly Compensation Amount \$4,000.00
 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

Death Result of Injury _____ Number of Dependents _____

DEPENDENT/PAYEE

Dependent/Payee Relationship	First Name	Last Name	Date of Birth

BENEFITS

Reduced Benefit Amount R - Reclassification of Benefit Non-Consecutive Period A - Adjustment/Credit/Redistribution
 Overpayment Amount - Current \$2,000.00
 Benefit Change Reason Code C - Recalculation of Net Weekly Amount based on Wage Statement

Benefits

Benefit Types										
080 - Employer's Liability										
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		
080	11/01/2020	11/30/2020	4	5	10/01/2020	\$3,000.00	10/01/2020	\$3,000.00	12/21/2020	\$12,000.00

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

PAYMENTS

Award/Order Date _____

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 xxxxx9987Insured FEIN xxxxx8776**CONCURRENT EMPLOYER INFORMATION**

Name _____ Contact Business Phone _____ Wage _____