Workers' Compensation Board

State of New York - Workers' Compensation Board

Subsequent Report of Injury
Report Type (MTC) CD-Compensable Death

S7744520

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.
No benefits are being paid at this time pending further Beneficiary investigation.

Employee Name John T Doe

WCB Case Number (JCN) G2687879 **Date of Injury** 04/04/2020

Claim Administrator Claim Number BRI-24 **Maintenance Type Code Date** 10/08/2020

Claim Type I - 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 09/15/1970

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx8767

CLAIM INFORMATION

Initial Date Employer Had Knowledge of Date of Disability 04/05/2020 **Employment Status** 1 - Regular/Full-time Employee

Pre-existing Disability **Number of Days Worked Per Week** 5

Work Days Scheduled (S-Scheduled N-Non Scheduled) S M T W T F S ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Work Week Type** S - Standard Work Week

Calculated Wage $1,200.00 **Wage Period** 01 - Weekly

Employer Paid Salary Prior To Acquisition **Denial Rescission Date**

Date Claim Administrator Notified of Employee Representation

EMPLOYEE INJURY

Full Wages Paid for Date of Injury _____

Type of Loss 01 - Traumatic Injury **Date of Maximum Medical Improvement** _____

Death Result of Injury Yes **Date of Death** 04/04/2020

WORK STATUS

Initial Date Disability Began 04/04/2020

BENEFITS

Reduced Benefit Amount _____

Overpayment Amount - Current _____

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

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx3423 **Insured FEIN** xxxxx6543

CONCURRENT EMPLOYER INFORMATION

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