

State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) EP-Employer Paid

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board. Employer is paying the injured employee's salary in lieu of compensation. The Claim Administrator is not paying indemnity benefits at this time.

Employee Name John T Doe

WCB Case Number (JCN) G2687878 **Date of Injury** 03/03/2020

Claim Administrator Claim Number BRI-23 **Maintenance Type Code Date** 10/08/2020

Claim Type L - Became Indemnity for Lost Time **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 09/15/1970

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx2323

CLAIM INFORMATION

Initial Date Employer Had Knowledge of Date of Disability 03/04/2020 Employment Status 1 - Regular/Full-time Employee
 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
10%	L - Left	13 - Ear(s)
50%	R - Right	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
41 - Son/Daughter (birth order 1)	John	Public	02/02/2002

WORK STATUS

First Day of Disability After The Waiting Period _____
 Current Date Last Day Worked _____
 Initial Date Disability Began 03/04/2020 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 A - Adjustment/Credit/Redistribution
 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	03/10/2020	03/11/2020	1	1	03/10/2020	\$1,000.00	03/10/2020	\$1,000.00	03/10/2020	\$1,000.00

Benefits - A - Adjustments / C - Credits / R - Redistributions

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount
070 - Temporary Partial	C	P - Advance	03/10/2020	03/10/2020	\$200.00

Other Benefits

Other Benefit Type	Amount

PAYMENTSAward/Order Date 03/10/2020**Recoveries**

Recovery Type	Amount
840 - Unspecified Recovery	\$25.00

EMPLOYER / INSURED INFORMATIONEmployer FEIN xxxxx2121Insured FEIN xxxxx1432**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.