Workers' Compensation Board

State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) IP-Initial Payment

S7744486

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 begun payment of indemnity benefits and payments are ongoing.

Employee Name John T Doe

WCB Case Number (JCN) G2687877 **Date of Injury** 08/08/2020

Claim Administrator Claim Number BRI-22 **Maintenance Type Code Date** 10/07/2020

Claim Type I - Indemnity for Lost Time **WCB Received Date** 10/07/2020

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 Mark 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 09/15/1950

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx2727

CLAIM INFORMATION

Initial Date Employer Had Knowledge of Date of Disability 08/09/2020

Current Date Employer Had Knowledge of Current Date of Disability

Pre-existing Disability

Work Days Scheduled (S-Scheduled N-Non Scheduled) S M T W T F S

Calculated Wage $1,200.00

Calculated Weekly Compensation Amount $1,000.00

Employer Paid Salary Prior To Acquisition

Date Claim Administrator Notified of Employee Representation

Employment Status 1 - Regular/Full-time Employee

Number of Days Worked Per Week 5

Work Week Type S - Standard Work Week

Wage Period 01 - Weekly

Denial Rescission Date

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

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 08/08/2020

Initial Date Disability Began 08/09/2020

Initial RTW Date

Initial RTW Type Code

Initial RTW Physical Restrictions

Initial RTW With Same Employer

Current Date Last Day Worked

Current Date Disability Began

Latest RTW/Status Date

Latest RTW Type Code

Latest RTW Physical Restrictions

Latest RTW With Same Employer

BENEFITS

Reduced Benefit Amount

Estimated Gross Weekly Amt.

Overpayment Amount - Current

Non-Consecutive Period

Benefits

Benefit Types
070 - Temporary Partial

Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross Effective Date	Weekly Gross Amount	Weekly Net Effective Date	Weekly Net Amount	Benefit Payment Issue Date	Amount Paid
070	09/01/2020	09/02/2020	1	1	09/01/2020	$900.00	09/01/2020	$900.00	09/01/2020	$900.00

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 09/01/2020

Payment Reasons
070 - Temporary Partial

Payment Reason Code	Payee	Start Date	Through Date	Issue Date	Amount Paid
070	John T Doe	09/01/2020	09/02/2020	09/01/2020	$900.00

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 INFORMATION

Employer FEIN xxxxx4444 **Insured FEIN** xxxxx1111

CONCURRENT EMPLOYER INFORMATION

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