Workers' Compensation Board

State of New York - Workers' Compensation Board

Subsequent Report of Injury
Report Type (MTC) PY-Payment Report

S7744510

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The Claim Administrator has made payment(s) as reflected in Benefits and/or Payments Section of this document.

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 P - Indemnity with No Lost Time Beyond Waiting Period **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

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 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

Initial Date Disability Began 03/04/2020

Initial RTW Date

Initial RTW Type Code

Initial RTW Physical Restrictions

Initial RTW With Same Employer

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 _____

Jurisdiction Claim Number - Related _____

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	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

Other Benefits

Other Benefit Type	Amount

PAYMENTS

Award/Order Date 03/10/2020 **Lump Sum Payment/Settlement** NS - Non-Specified Lump Sum Payment

Payment Reasons					
070 - Temporary Partial					
Payment Reason Code	Payee	Start Date	Through Date	Issue Date	Amount Paid
070	John T Doe	03/10/2020	03/11/2020	03/10/2020	$1,000.00

Recoveries

Recovery Type	Amount

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx2121 **Insured 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.