

State of New York - Workers' Compensation Board

Subsequent Report of Injury Report Type (MTC) SU-Sync Up

This paper contains information that has been provided electronically to the Board. Do <u>not</u> serve a copy of this on the Board.

Employee Name John T	Doe			
WCB Case Number (JCN)	G2687878		Date of Injury 03/03/2	2020
Claim Administrator Clain	Number BRI-23		Maintenance Type Co	de Date 10/08/2020
			WCB Received Date	10/08/2020
		INSURER INFORMAT	ΓΙΟΝ	
FEIN xxxxx6212			Insurer ID	W212500
	CLAI	M ADMINISTRATOR INF	FORMATION	
Name All American Insu	urance Company		FEIN	xxxxx6212
Claim Representative Nan	ne Mary Clark		Postal Code	12202
Claim Representative Bus	iness Phone Number	5185551212		
E-mail Address mclark@a	llamerican.com			Claim Admin ID W212500
		DENIAL REASON	S	
Partial Denial Reason				
Partial Denial Effective Da	te	_		
Full Denial Effective Date	_	_		
Full Denial Reason				
Denial Reason Narrative				
		EMPLOYEE INFORMA	ATION	
First Name	John		Middle Name/l	nitial _ T
Last Name	Doe		Suffix	
Date of Birth	09/15/1970			
Employee ID Type	S - Employee Social Sec	curity Number	Employee ID	xxxxx2323
		CLAIM INFORMATI	ON	
Employer Paid Salary Pric	or To Acquisition			

PERMANENT IMPAIRMENT

Impairment Percentage	Body Part Location	Body Part	
10%	L - Left	13 - Ear(s)	
50%	R - Right	36 - Finger(s) other than thumb	

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

	Current Date Disability Began					
SUSPENSION						
Suspension Effective Date	Suspension Reason Code - Full					
Suspension Reason						
	DENEETO					
	BENEFITS					

Benefits

Overpayment Amount - Current

Benef	Benefit Types									
070	070 - Temporary Partial									
Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Effoctivo	eekly Gross Amount	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	Туре	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount
070 - Temporary Partial	С	P - Advance	03/10/2020	03/10/2020	\$200.00

Other Benefits

Other Benefit Type	Amount

P	Δ	٧N	ΛF	N٦	rs.

Lump Sum Payment/Settlement

Non-Consecutive Period A - Adjustment/Credit/Redistribution

Recoveries

Recovery Type	Amount
840 - Unspecified Recovery	\$25.00

Reduced Earnings

Actual Reduced	Reduced Earnings Week	Reduced Earnings Week	Reduced Earnings Net Weekly Amount Due
Earnings	Start Date	End Date	By Claim Administrator

		EMPLOYER / INSURED INFORMAT	TON			
Employer FEIN	xxxxx2121					
CONCURRENT EMPLOYER INFORMATION						
Name		Contact Business Phone	Wage			