

State of New York - Workers' Compensation Board
Subsequent Report of Injury
Report Type (MTC) SX-Full Suspension

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 suspended indemnity benefits for the reasons reflected in the Suspension Section of this document.

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** 10/08/2020

Claim Type I - Indemnity for Lost Time **WCB Received Date** 10/08/2020

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 09/15/1950

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 **Employment Status** 1 - Regular/Full-time Employee

Current Date Employer Had Knowledge of Current Date of Disability _____ **Work Week Type** S - Standard Work Week

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

Calculated Wage \$1,200.00 **Anticipated Wage Loss** _____

Calculated Weekly Compensation Amount \$1,000.00

Employer Paid Salary Prior To Acquisition _____

Date Claim Administrator Notified of Employee Representation _____

EMPLOYEE INJURYFull Wages Paid for Date of Injury NoType of Loss 01 - Traumatic Injury

Date of Maximum Medical Improvement _____

PERMANENT IMPAIRMENT

Impairment Percentage	Body Part Location	Body Part
50%	R - Right	35 - Hand

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 STATUSInitial Date Disability Began 08/09/2020

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 _____

SUSPENSIONSuspension Effective Date 10/02/2020 Suspension Reason Code - Full S2 - Suspension, Medical Non-Compliance**Suspension Reason**

Suspended for medical non-compliance today.

BENEFITSReduced Benefit Amount R - Reclassification of Benefit

Estimated Gross Weekly Amt. _____

Overpayment Amount - Current \$500.00**Benefits**

Benefit Types										
050 - Temporary Total										
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		
050	09/01/2020	09/02/2020	1	1	09/01/2020	\$1,000.00	09/01/2020	\$1,000.00	09/01/2020	\$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
310 - Total Penalties	\$500.00

PAYMENTSAward/Order Date 09/01/2020**Recoveries**

Recovery Type	Amount
830 - Overpayment Recovery	\$500.00

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 INFORMATIONEmployer FEIN xxxxx4444Insured FEIN xxxxx1111**CONCURRENT EMPLOYER INFORMATION**

Name _____ Contact Business Phone _____ Wage _____