New York State Workers' Compensation Board

S7744759

State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) UR-Upon Request (Grandfathered)

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Employee Name John T Doe

WCB Case Number (JCN) G2687912

Date of Injury 01/01/2010

Claim Administrator Claim Number VPAL134

Maintenance Type Code Date 12/04/2020

Claim Type I - Indemnity for Lost Time

WCB Received Date 12/04/2020

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 Mary Clark

Postal Code 12202

Claim Representative Business Phone Number 5185185181

E-mail Address mclark@allamerican.com

Claim Admin ID W212500

Late Reason

DENIAL REASONS

Partial Denial Reason

Full Denial Effective Date

Full Denial Reason

Denial Reason Narrative

EMPLOYEE INFORMATION

First Name John

Middle Name/Initial T

Last Name Doe

Suffix

Date of Birth 02/19/1970

Employee ID Type S - Employee Social Security Number

Employee ID xxxxx1234

CLAIM INFORMATION

Initial Date Employer Had Knowledge of Date of Disability 01/01/2010

Current Date Employer Had Knowledge of Current Date of Disability 01/01/2010

Pre-existing Disability ______

Work Days Scheduled (S-Scheduled N-Non Scheduled)

S	M	T	W	T	F	S

Calculated Wage ______

Calculated Weekly Compensation Amount ______

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

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 ______

Initial Date Disability Began 01/01/2010

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 ______

SUSPENSION

Suspension Effective Date ______

Suspension Reason

BENEFITS

Reduced Benefit Amount ______________________

Non-Consecutive Period ______________________

Estimated Gross Weekly Amt. __________

Overpayment Amount - Current ______________________

Jurisdiction Claim Number - Related ______________________

Benefits

Benefit Types										
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

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 ______________

Recoveries

Recovery Type	Amount

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx8768

Insured FEIN xxxxx8768

CONCURRENT EMPLOYER INFORMATION

Name ______________________ **Contact Business Phone** ______________ **Wage** ______________