F6483832

State of New York - Workers' Compensation Board

First Report of Injury
Report Type (MTC) 00-Original

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Employee Name Jane Smith

WCB Case Number (JCN) 55555557

Date of Injury 01/01/2017

Claim Administrator Claim Number 55555557

Maintenance Type Code Date 01/22/2022

Claim Type M - Medical Only

WCB Received Date 01/22/2022

Agreement to Compensate

INSURER INFORMATION

Insurer Name Uninsured Employers Fund TPA

FEIN xxxxx9999

Insurer Type

Insurer ID W999999

CLAIM ADMINISTRATOR INFORMATION

Name Uninsured Employers Fund TPA

Info/Attn

Address 328 STATE STREET

City SCHENECTADY

State NY

Postal Code 12305

Country

FEIN xxxxx9999

Claim Admin ID W999999

Late Reason

Claim Representative Name TEST

Claim Representative Business Phone Number 5180000001

Claim Representative E-mail Address TEST@GMAIL.COM

EMPLOYEE INFORMATION

Field	Value	Field	Value
First Name	Jane	Middle Name/Initial	
Last Name	Smith	Suffix	
Mailing Address	WCB ATTN JEFFREY SMITH		
City	SCHENECTADY	State	NY
Postal Code	12305	Country	
Phone Number		Gender	M - Male
Date of Birth	01/02/1963	Date of Hire	01/01/2001
Employee ID Type	S - Employee Social Security Number	Employee ID	xxxxx7777
Occupation Description	FAKE		
Employee Email Address			

CLAIM INFORMATION

Field	Value	Field	Value
Time of injury	01:00	Date Employer Had Knowledge of the Injury	01/01/2017
Employment Status	1 - Regular/Full-time Employee	Date Claim Administrator Had Knowledge of the Injury	01/01/2017
Wage Period	01 - Weekly	Initial Date Employer Had Knowledge of Date of Disability	01/01/2017
Estimated Wage	$100.00	Current Date Employer had Knowledge of Current Date of Disability	
Work Week Type	S - Standard Work Week	Number of Days Worked Per Week	
Date of Denial Rescission		Work Days Scheduled (S-Scheduled N-Non Scheduled)	S M T W T F S

EMPLOYEE INJURY

Full Wages Paid for Date of Injury No

Employer Paid Salary in Lieu of Compensation

Death Result of Injury

Date of Death

Number of Dependents

Nature of Injury 04 - Burn

Part of Body

Part of Body Injured Location	Part of Body Injured	Part of Body Injured Fingers/Toes Location
R - Right	13 - Ear(s)	

Cause of Injury 10 - Caught In, Under or Between - Machine or Machinery

Type of Loss 01 - Traumatic Injury

Accident/Injury Description

FAKE FAKE FAKE

WORK STATUS

Initial Date Last Day Worked	01/01/2017	**Initial RTW Type Code**	
Initial Date Disability Began	01/01/2017	**Initial RTW Physical Restrictions**	
Initial RTW Date		**Initial RTW With Same Employer**	
Latest RTW Type Code		**Latest RTW Physical Restrictions**	
Latest RTW/Status Date		**Latest RTW With Same Employer**	
Current Date Disability Began		**Current Date Last Day Worked**	
		First Day of Disability After the Waiting Period	

ACCIDENT LOCATION AND WITNESSES

Premises E - Employer

Organization Name FAKE FAKE FAKE

Street	328 STATE STREET	**State**	NY
City	SCHENECTADY	**Postal Code**	12305
County/Parish	Albany - Albany	**Country**	

Location Narrative

Witnesses	**Business Phone Number**

MEDICAL TREATMENT

Initial Treatment 3 - Emergency Evaluation, Diagnostic Testing, and Medical Procedures

Managed Care Org.

Managed Care Org. ID

EMPLOYER INFORMATION

Name MR FAKE

Employer FEIN xxxxx4234

Industry Code 453210

UI Number

Manual Classification 0917 - Domestic Service Contractor-Inside

Info/Attn

Mailing Address 328 STATE STREET

City SCHENECTADY

State NY

Postal Code 12305

Country

Physical Addr TEST

City SCHENECTADY

State NY

Postal Code 12305

Country

Contact Name FAKE FAKE

Contact Business Phone Number 5555555755

INSURED INFORMATION

Insured Name

Insured FEIN

Insured Type U - Uninsured

Insured Location ID

Policy Number ID

Policy Effective Date 01/01/2001

Policy Expiration Date