Workers' Compensation Board

State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) PD-Partial Denial

S7744507

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 denied indemnity benefits in part or whole but is not denying medical benefits. If Claim Administrator denies medical benefits, they will file Form C-8.1

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

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 5185551212

E-mail Address mclark@allamerican.com

Claim Admin ID W212500

Late Reason

PARTIAL DENIAL REASON

Partial Denial Reason B - Denying Indemnity in Part, not Medical

Partial Denial Effective Date 10/05/2020

Denial Reason Narrative

Denying this for a very good 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

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

Anticipated Wage Loss

Denial Rescission Date

EMPLOYEE INJURY

Full Wages Paid for Date of Injury No

Type of Loss 01 - Traumatic Injury

Death Result of Injury **Date of Death**

Employer Paid Salary in Lieu of Compensation No

Date of Maximum Medical Improvement

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 08/09/2020

Initial RTW Date

Initial RTW Type Code

Initial RTW Physical Restrictions

Initial RTW With Same Employer

Current Date Disability Began

Latest RTW/Status Date

Latest RTW Type Code

Latest RTW Physical Restrictions

Latest RTW With Same Employer

BENEFITS

Reduced 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** Effective Date	Amount	**Weekly Net** Effective Date	Amount	Benefit Payment Issue Date	Amount Paid
050	09/01/2020	10/02/2020	4	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
050 - Temporary Total	A	W - Partial Wage Continuation	10/01/2020	10/02/2020	$1,000.00

Other Benefits

Other Benefit Type	Amount
310 - Total Penalties	$500.00

PAYMENTS

Award/Order Date 09/01/2020

Recoveries

Recovery Type	Amount
830 - Overpayment Recovery	$500.00

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx4444 **Insured FEIN** xxxxx1111

CONCURRENT EMPLOYER INFORMATION

Name _____ **Contact Business Phone** _____ **Wage** _____