

State of New York - Workers' Compensation Board
Subsequent Report of Injury
Report Type (MTC) SA-Sub-Annual

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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

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

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

BENEFITS

Overpayment Amount - Current \$500.00

Benefits

Benefit Types										
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		

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

Recoveries

Recovery Type	Amount
830 - Overpayment Recovery	\$500.00

CONCURRENT EMPLOYER INFORMATION

Name _____ Contact Business Phone _____ Wage _____