



CASE INFORMATION

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|-------------------------|------------------------------|----------------------------|
| WCB Case ID 55555555 | Date of Injury 01/01/2020 | Claim Admin Claim # 555 |
|-------------------------|------------------------------|----------------------------|

Claimant Name Fake, Case

Claimant Counsel Name Matt Tester

Representative ID [REDACTED]

Employer Name NYS WCB Fake Case Primary Employer

Insurer Name WCB Test Insurer Attn: Michael [REDACTED]

Insurer ID [REDACTED]

Claim Admin Name WCB Test Insurer Attn: Michael [REDACTED]

Claim Admin ID [REDACTED]

RFA-1LC SUMMARY

Summary of selected request reason(s):

1. Claimant, Attorney, or Licensed Representative has not been paid per decision or was paid late
2. Claimant has discontinued or settled a lawsuit pertaining to this case

Additional proposed findings:

1. Establish average weekly wage (AWW)

RFA-1LC REQUEST DETAILS

1. Claimant, Attorney, or Licensed Representative has not been paid per decision or was paid late

| Form ID | Received Date | Document ID | Category of Payment | Unpaid Amount | Late Payment Amount | Late Payment Date |
|---------|---------------|-------------|--------------------------|---------------|---------------------|-------------------|
| EC-23 | [REDACTED] | [REDACTED] | Award of Compensation | \$2000.00 | \$100.00 | 02/23/2025 |
| | | | Medical & Transportation | \$100.00 | \$25.00 | 02/23/2025 |

Additional information related to this reason: Entering additional information related to this reason free form text box for example. Entering additional information related to this reason free form text box for example. Entering additional information related to this reason free form text box for example. Entering additional information related to this reason free form text box for example.

2. Claimant has discontinued or settled a lawsuit pertaining to this case

The settlement documents listed below are required.

Documentation: Closing statement and consent letter

ADDITIONAL PROPOSED FINDINGS

1. Establish average weekly wage (AWW)

Will the proposed AWW result in an adjustment to prior payments or continuing payments? No

Primary employer AWW: \$500.00

The AWW was calculated using the following method: Per First Report of Injury (FROI)/Subsequent Report of Injury (SROI)

SUPPORTING DOCUMENTATION

Referenced Document(s):

| Form ID | Medical Service Date | Document ID | Received Date |
|-----------|----------------------|-------------|---------------|
| ATTY-CORR | | | |

CERTIFICATION

The following request(s) require certification:

1. *Claimant, Attorney, or Licensed Representative has not been paid per decision or was paid late*
2. *Claimant has discontinued or settled a lawsuit pertaining to this case*
3. *Additional Proposed Findings: Establish average weekly wage (AWW)*

I certify that I have attempted to contact the opposing party(ies) or its representative(s) to discuss the reason(s) selected, and have waited at least 24 hours for a response, but that no discussion was forthcoming.

| First Name | Last Name | Name Unknown | Organization Name | Date | Phone | Email |
|------------|-----------|--------------|-------------------|------------|------------|----------------|
| John | Tester | | ABC Test LLC | 03/03/2025 | 5184578888 | test@email.com |

ATTESTATION

I affirm that:

- (1) my statements are true and correct, and
- (2) I am authorized to submit this request, and
- (3) this request for Board action is based upon reasonable grounds, has been submitted with my client's consent, and that this form with attachment(s) has been provided to the opposing party(ies), and
- (4) I accept that the electronic submission of this form to the Workers' Compensation Board is equivalent to placing my signature on the request.

Claimant Counsel Name: Matt Tester

Email: testeremail@wcb.com

Date: 03/07/2025

Phone Number: 5184579999 **Ext.:** 123