

State of New York - Workers' Compensation Board
First Report of Injury
Report Type (MTC) 02-Change

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.

Pursuant to 12 NYCRR §300.22, when the claim administrator is changing the Agreement to Compensate Code from Without Liability to With Liability, this notice must be served on the claimant and his or her attorney or licensed representative, if any, within one business day of the date it is filed electronically with the chair.

Employee Name Jane Smith

WCB Case Number (JCN) 5555557 **Date of Injury** 01/01/2017

Claim Administrator Claim Number 5555557 **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

FULL DENIAL REASONS

Full Denial Effective Date _____

EMPLOYEE INFORMATION

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 JSmith@fake.com

CLAIM INFORMATION

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	<u>01/01/2017</u>	Initial RTW Type Code	_____
Initial Date Disability Began	<u>01/01/2017</u>	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** _____

CHANGE DATA ELEMENTS

Change Data Element/Segment Number	Change Reason Code
0443 - Employee Email Address	A - Add