pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

AGREEMENT FOR COMPENSATION FOR DISABILITY OR PERMANENT INJURY

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

- -

DATE OF INJURY

- -

MM DD YYYY

WCAIS CLAIM NUMBER

EMPLOYEE

First name

Last name

Date of birth

Address

Address

City/Town State ZIP

County

Telephone

EMPLOYER

Name

Address

Address

City/Town State ZIP

County

Telephone FEIN

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name

Address

Address

City/Town State ZIP

County

Telephone FEIN

Contact

NAIC code or Insurer code

Insurer/TPA claim #

INJURY INFORMATION

Part of body injured

Nature of injury

Accident/injury description narrative

Check if occupational disease

NOTICE: Agreement should be clearly completed, (preferably typed) and uploaded in accordance with the provisions of the EDI Implementation Guide. A copy must be sent to the employee. Wage information must be completed in accordance with the Pennsylvania Workers' Compensation Act, and sent to the employee.

DATE DISABILITY BEGAN - -

MM DD YYYY

The employer shall pay the employee compensation at a rate of $ per week on an average weekly wage of $ beginning - - .

MM DD YYYY

Date first check mailed . If the date exceeds the 21-Day Rule, check this box
And explain under "further matters agreed upon" on reverse.

Payment of medical and hospital expenses are subject to the limits of time and amount provided by the Pennsylvania Workers' Compensation Act and subject to modification or termination with the Act.

Compensation payable for weeks days for loss or loss of use of under Section 306(c).

Compensation payable for weeks days for healing period for loss or loss of use of under Section 306(c).

Compensation payable for weeks days for disfigurement under Section 306(c). Please describe the disfigurement.

Further matters agreed upon:

We, the undersigned, agree upon the matters represented herein by the above named employee and the above named employer.

Employee's signature

Date of agreement

MM - DD - YYYY

Claims Representative's signature

Claims Representative's name (typed/printed)

Telephone

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
toll-free inside PA TTY: 800.362.4228
local & outside PA TTY: 717.772.4991

Email
ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

NOTICE OF COMPENSATION PAYABLE

DATE OF NOTICE
MM - DD - YYYY

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

DATE OF INJURY
MM - DD - YYYY

WCAIS CLAIM NUMBER

EMPLOYEE

First name
Last name
Date of birth
Address
Address
City/Town State ZIP
County
Telephone

EMPLOYER

Name
Address
Address
City/Town State ZIP
County
Telephone FEIN

INJURY INFORMATION

Part of body injured
Nature of injury
Accident/injury description narrative
Check if occupational disease ☐

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name
Address
Address
City/Town State ZIP
County
Telephone FEIN
Contact
NAIC code or Insurer code
Insurer/TPA claim #

NOTICE TO EMPLOYER: This Notice should be clearly completed, (preferably typed) and filed with the Bureau. Filing with the Bureau by electronic batch upload in WCAIS, by electronically attaching the document to a claim in WCAIS, or by mail. A copy must be sent to the injured employee with the first payment of compensation.
NOTICE TO EMPLOYEE: If any questions arise regarding these payments, contact the representative named at the bottom of this Notice. If you cannot resolve a problem with the employer representative, you may call the Bureau at 800-482-2383.

Compensation is payable as follows:

☐ Check only if compensation for medical treatment **(medical only, no loss of wages)** will be paid subject to the Workers' Compensation Act. Compensation for medical treatment is payable from date of injury.
For compensation for medical treatment only, you should not complete numbers 1 through 5.

1. Weekly compensation rate $ Based on an average weekly wage of $
2. Payments begin on MM - DD - YYYY (Compensation for loss of wages is payable for first 7 days only if disability extends 14 or more days; compensation for medical treatment is payable from the date of injury.)
3. Date first check mailed MM - DD - YYYY if the date exceeds the 21-Rule, check this box ☐ and explain on back of this form.
4. Payments will hereafter be made: ☐ Weekly ☐ Biweekly ☐ Other (Specify):

Any termination, suspension or modification of these payments must be made by agreement, final receipt, administrative or judicial determination, or as otherwise provided in the Workers' Compensation Act or Regulations of the Department.

(OVER)

5. If injury involves loss under Section 306(c) (except for disfigurement of the head, face or neck) and employee has returned to work, complete the following information.

   (a) Compensation is payable for ____ weeks ____ days for loss or loss of use of _____

   (b) Employee returned to work without loss of income on ____ - ____ - ____
   MM DD YYYY

   (c) Healing period payable for ____ weeks ____ days (Up to (b) above and subject to 7-day waiting period)

   (d) Total (a) and (c) payable ____ weeks ____ days.

   (e) Credit taken for disability benefits paid $ ____ . ____

6. Remarks:

Claims representative's name (typed/printed) _____ Telephone _____

Claims representative's signature

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 S. CAMERON STREET, ROOM 103
HARRISBURG, PA 17104-2501
(TOLL FREE) 800.482.2383

Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
toll-free inside PA TTY: 800.362.4228
local & outside PA TTY: 717.772.4991

Email
ra-li-bwc-helpline@pa.gov

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

NOTICE OF TEMPORARY COMPENSATION PAYABLE

DATE OF NOTICE
MM - DD - YYYY

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

DATE OF INJURY
MM - DD - YYYY

WCAIS CLAIM NUMBER

EMPLOYEE

First name
Last name
Date of birth
Address
Address
City/Town State ZIP
County
Telephone

EMPLOYER

Name
Address
Address
City/Town State ZIP
County
Telephone FEIN

INJURY INFORMATION

Part of body injured
Nature of injury
Accident/injury description narrative

Check if occupational disease ☐

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name
Address
Address
City/Town State ZIP
County
Telephone FEIN
Contact
NAIC code or Insurer code
Insurer/TPA claim #

NOTICE TO EMPLOYER: In wage loss claims, a copy of the Notice is to be sent to the injured employee with the first payment of **temporary** compensation. The original must be filed with the Department of Labor & Industry. Filing with the Department may be completed by electronic batch uploaded in WCAIS, by electronically attaching the document to a claim in WCAIS, or by mail. In wage loss claims, the 90 day period begins on the first day of disability. The employer's/insurer's failure to file a notice as provided in Section 406. 1(d)(5) of the Act advising the employee that the employer is ceasing temporary compensation shall be deemed an admission of liability, and this notice shall be converted to a Notice of Compensation Payable.
NOTICE TO EMPLOYEE: This Notice of **temporary** compensation payments is for a period of up to 90 days and **is not** an admission by your employer that it is responsible for your injury. If any questions arise, contact the representative at the bottom of this Notice. If you need further information, call the Bureau at 800-482-2383.

Compensation is payable as follows:

☐ Check only if compensation for medical treatment **(medical only, no loss of wages)** will be paid subject to the Workers' Compensation Act. Compensation for medical treatment is payable from date of injury. If employer stops temporary compensation in accordance with the Act, employer will not pay for treatment received on or after the stoppage date. For compensation for medical treatment only, you should not complete numbers 1 or 3.

1. Weekly compensation rate $

   Based on an average weekly wage of $ (A statement of wages must accompany this form.)

2. Ninety-day period begins on MM - DD - YYYY and ends on MM - DD - YYYY

3. Payments will hereafter be made: ☐ Weekly ☐ Biweekly ☐ Other (Specify)

   until payments cease or the ninety-day maximum period for temporary compensation expires.

Claims representative's name _____ Telephone _____

Claims representative's signature

(OVER)

4. Remarks

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
toll-free inside PA TTY: 800.362.4228
local & outside PA TTY: 717.772.4991

Email
ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

NOTICE STOPPING TEMPORARY COMPENSATION

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

DATE OF INJURY (MM - DD - YYYY)

WCAIS CLAIM NUMBER

EMPLOYEE

First name _____

Last name _____

Date of birth _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____

EMPLOYER

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

NAIC code _____ or Insurer code _____

Insurer/TPA claim # _____

DATE OF THIS NOTICE (MM - DD - YYYY)

NOTICE TO EMPLOYEE: This notice is being sent because payment of compensation, being paid pursuant to the Notice of Temporary Compensation Payable, is being stopped as of (MM - DD - YYYY).

The payment of temporary compensation does not mean that your employer assumed responsibility for your injury. Your employer and you retain all rights, defenses and obligations with regard to the claim. Further, the payment of temporary compensation may not be used to support a claim for benefits in a future proceeding.

☐ WE HAVE ACCEPTED RESPONSIBILITY FOR YOUR CLAIM, AND ATTACHED IS A *NOTICE OF COMPENSATION PAYABLE* OR AN *AGREEMENT FOR COMPENSATION*; **OR**

☐ WE HAVE DECIDED NOT TO ACCEPT LIABILITY, AND ATTACHED IS A *NOTICE OF WORKERS' COMPENSATION DENIAL*. IF YOU BELIEVE YOU SUFFERED A WORK-RELATED INJURY, YOU WILL BE REQUIRED TO FILE A CLAIM PETITION WITH THE WORKERS' COMPENSATION OFFICE OF ADJUDICATION IN ORDER TO PROTECT YOUR FUTURE RIGHTS.

You have three years from the date of injury or discovery of your condition to file a Claim Petition for benefits. Since time limits can vary depending on the facts of your situation, you may wish to contact an attorney if you believe you may have a claim.

Authorized Agent for Insurer or TPA (if self-insured) _____

Claims Representative's signature _____

Claims Representative's name (typed/printed) _____

Telephone _____

NOTICE TO INSURER: This form must be either electronically filed in WCAIS or mailed to the Bureau of Workers' Compensation, 1171 South Cameron Street, Room 103, Harrisburg, PA 17104-2501 no later than five days after the last payment of temporary compensation. A copy must be sent to the employee.

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
toll-free inside PA TTY: 800.362.4228
local & outside PA TTY: 717.772.4991

Email
ra-li-bwc-helpline@pa.gov

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Equal Opportunity Employer/Program

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

NOTICE OF WORKERS' COMPENSATION DENIAL

DATE OF NOTICE
MM - DD - YYYY

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

DATE OF INJURY
MM - DD - YYYY

WCAIS CLAIM NUMBER

EMPLOYEE

First name
Last name
Date of birth
Address
Address
City/Town State ZIP
County
Telephone

EMPLOYER

Name
Address
Address
City/Town State ZIP
County
Telephone FEIN

ALLEGED INJURY INFORMATION

Part of body injured
Nature of injury
Accident/injury description narrative

Check if occupational disease ☐

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name
Address
Address
City/Town State ZIP
County
Telephone FEIN
Contact
NAIC code or Insurer code
Insurer/TPA claim #

NOTICE: The employer/insurer has decided to deny you workers' compensation benefits. You have the right to contest this denial by timely filing a petition with the bureau. Petitions may be either electronically filed in WCAIS or sent to the Workers' Compensation Office of Adjudication, 1010 N. Seventh St., Suite 202, Harrisburg, PA 17102-1400.

Do not use this form to accept a medical-only claim. This denial shall be sent to the employee or dependent and filed with the bureau by electronic batch upload in WCAIS, by electronically attaching the document to a claim in WCAIS or by mail no later than 21 days after notice or knowledge to the employer of the employee's disability or death.

Date the employer received notice or knew of alleged injury or date of employee's claimed disability: MM - DD - YYYY
This date must be completed.

The employer/insurer declines to pay workers' compensation benefits to claimant because:

1. The employee did not suffer a work-related injury. The definition of injury also includes aggravation of a pre-existing condition, or disease contracted as a result of employment.
2. The injury was not within the scope of employment.
3. The employee was not employed by the defendant.
4. The employee has not suffered a loss of wages as a result of an already accepted injury.
5. The employee did not give notice of his/her injury or disease to the employer within 120 days within the meaning of Sections 311-313 of the Workers' Compensation Act.
6. Other good cause. Please explain fully in the space below.

See Reverse Side For Employees' Rights To Contest Denial

Claims representative's name (typed/printed) _____ Telephone _____

_____
Claims representative's signature

EMPLOYEES' RIGHTS TO CONTEST DENIAL

You have the right to contest this denial of your claim for workers' compensation benefits. Your petition will be heard by a workers' compensation judge. You and your employer will have the opportunity to testify and provide medical evidence with respect to your claim. Both you and your employer will have the right to bring witnesses. You may retain an attorney to represent you in this proceeding although representation by an attorney is not required by law. Because of the legal complications that can arise in occupational disease and workers' compensation cases, you may want to consider legal advice. **If you do not know how to contact an attorney, please contact your local Bar Association or the Pennsylvania Bar Association at 800-692-7375 for guidance in obtaining an attorney.**

The procedure for filing a petition is as follows:

1. To file a petition you may log onto the WCAIS system at www.dli.state.pa.us/WCAIS, or upon request, a petition, Form LIBC-362, will be mailed to you. You or your attorney must complete and return the original petition to the Workers' Compensation Office of Adjudication by electronically attaching the document to a claim in WCAIS or by mail to the Workers' Compensation Office of Adjudication, 1010 N. Seventh St., Suite 202, Harrisburg, PA 17102-1400.

2. A petition for an injury must be filed within three years of the date of injury. For occupational disease claims, disability or death must occur within 300 weeks from last exposure. A petition must be filed no later than three years from that date. Failure to file a petition within these rules may result in a loss of your claim.

3. You must give notice of your work-related injury or disease to your employer within 120 days of the date you knew (or should have known) that you were injured or had contracted a work-related disease.

4. When your petition is received by the Workers' Compensation, Office of Adjudication, it will be assigned to a judge for hearing. You will be notified of your hearing date. All parties are requested to be fully prepared prior to the first hearing.

If you need petition forms or have questions, please contact the Workers' Compensation, Office of Adjudication.

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
toll-free inside PA TTY: 800.362.4228
local & outside PA TTY: 717.772.4991

Email
ra-li-bwc-helpline@pa.gov

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Equal Opportunity Employer/Program

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
WORKERS' COMPENSATION OFFICE OF ADJUDICATION

CLAIM PETITION FOR WORKERS' COMPENSATION

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

DATE OF INJURY (MM - DD - YYYY)

WCAIS CLAIM NUMBER

EMPLOYEE

First name _____

Last name _____

Date of birth _____

If deceased - Dependent/Guardian/Personal Representative

First name _____

Last name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____ Telephone _____

EMPLOYER

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

VS. INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

NAIC code _____ or Insurer code _____

Insurer/TPA claim # _____

1. Complete description of injury or illness including all parts of body affected. (If you are seeking additional compensation from the Subsequent Injury Fund for total disability as a result of a previous permanent loss, or loss of use of one hand, one arm, one foot, one leg or one eye, and a subsequent injury causing loss, or loss of use of, another hand, arm, foot, leg or eye, you must also submit from LIBC-375).

2. If occupational disease, give the last date of employment ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY) and/or last date of exposure ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY) with this employer.

3. Give date of injury or onset of disease ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY).

4. How did the injury or disease happen?

5. Did injury or disease occur on employer's premises? ☐ Yes ☐ No Where? (Be specific)

6. Notice of your injury or disease was served on your employer on ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY) in the following manner:

7. What was your job title at the time of injury or disease?

8. Were you working for more than one employer at the time of your injury? ☐ Yes ☐ No If yes, list additional employers:

9. Did this problem cause you to stop working? ☐ Yes ☐ No If yes, give date ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY).

10. Are you back to work with the same employer? ☐ Yes ☐ No If yes, ☐ Regular job ☐ Other job/give title

11. Are you back to work with another employer? ☐ Yes ☐ No If yes, give name and address of new employer:

12. What were your wages at the time of injury? $[ ][ ][ ][ ] . [ ][ ] ☐ Hour ☐ Day ☐ Week

13. If you have returned to work since your injury or illness, are you earning ☐ More ☐ Same ☐ Less than you were at the time of injury? Current earnings $[ ][ ][ ][ ] . [ ][ ] ☐ Hour ☐ Day ☐ Week

14. I am seeking payment for (check all that apply):

☐ Loss of wages

☐ Partial disability from [ ][ ] - [ ][ ] - [ ][ ][ ][ ] thru [ ][ ] - [ ][ ] - [ ][ ][ ][ ] (date disability ends) or ☐ ongoing.
MM DD YYYY MM DD YYYY

☐ Full disability from [ ][ ] - [ ][ ] - [ ][ ][ ][ ] thru [ ][ ] - [ ][ ] - [ ][ ][ ][ ] (date disability ends) or ☐ ongoing.
MM DD YYYY MM DD YYYY

☐ Medical bills (Attach additional sheet giving name of health care provider, address, type of treatment and amount of bill).

☐ Counsel fees to be paid by the employer.

☐ Loss or loss of use of arm, hand, finger, leg, foot or toe.

☐ Disfigurement (scars) of head, face or neck.

☐ Loss of sight.

☐ Loss of hearing.

☐ Cancer as a firefighter under Act 46 of 2011.

15. Other _____

16. Is there other pending litigation in this case? ☐ Yes ☐ No If yes, explain below:

PLEASE ENTER MY APPEARANCE FOR PETITIONER:

Attorney's name _____

PA Attorney ID number _____

Firm name _____

Address _____

Address _____

City/Town _____ State _____ ZIP _____

Telephone _____

Date of petition
[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
MM DD YYYY

_____
Attorney's signature

Notice: This petition must be filled out as fully as possible. If not filing electronically, the original must be sent to the Workers' Compensation Office of Adjudication, 1010 N. Seventh St, Suite 202, Harrisburg, PA, 17102-1400. You must send a copy to all other parties, and on the attorneys of all other parties, if the attorneys are known. A Proof of Service must be attached. A Proof of Service is a signed statement signed by you verifying that you have sent a copy of the petition to all parties and their attorneys, if known. Questions regarding the completion of this form may be directed to the Bureau of Workers' Compensation Claims Information Services.

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
toll-free inside PA TTY: 800.362.4228
local & outside PA TTY: 717.772.4991

Email
ra-li-bwc-helpline@pa.gov

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Equal Opportunity Employer/Program

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
WORKERS' COMPENSATION OFFICE OF ADJUDICATION

Date of Notice: 07/17/2014

ASSIGNMENT OF PETITION(S) TO A WORKERS' COMPENSATION JUDGE

WCAIS Claim Number:
Injury Date: 09/28/2013
Dispute Number:
Insurer Claim Number:
Claimant/Employee WCID Number:

Judge: David Cicola
Judge's Address:

Petitions:
Petition To/For (LIBC-378) - Suspend Compensation Benefits

Assignment County:
Cambria

Ebensburg, PA 15931–2085

vs

Franklin, PA 16323–6207

William M Conwell, ESQ.
4750 US STEEL TOWER
600 GRANT ST
PITTSBURGH, PA 15219

Philadelphia, PA 19106–3703

Lexington, KY 40512–4151

COPY OF PETITION PROVIDED TO ADVERSE PARTY WITH THIS NOTICE

The Special Rules of Administrative Practice and Procedure Before Referees, 34 Pa. Code, Chapter 131, control the conduct of hearings. Be prepared to present and/or exchange evidence at the first hearing as directed by the Judge.

The Judge will notify all parties of the time and place of the hearing.

The responding party (not the party filing petition(s)) should file an answer within twenty(20) days from the date of this notice. Answers can be filed electronically through WCAIS at Http://www.dli.state.pa.us/wcais, or by mailing it to the address below. Facts alleged in the petition(s) will be deemed to be admitted unless specifically denied. The failure of any party to specifically deny a fact alleged in the petition(s) shall not prelude the Judge from requiring proof of such fact at a hearing.

If a party fails to appear in person or by counsel at a scheduled hearing without adequate excuse, the Judge shall decide the matter on the basis of the petition and the evidence presented.

VOLUNTARY MEDIATION
To request voluntary mediation conference by a Judge, submit the request online at Http://www.dli.state.pa.us/wcais, or contact the Judge, or the office of any of the Judges listed on the website, http://www.dli.state.pa.us.

Accommodation: If you require a special accommodation to participate in a hearing due to a physical impairment, or need a language interpreter (or a sign language interpreter without cost), call or write the Judges' office assigned to your case and describe the accommodation. The Bureau Headquarters' Administrative Chief can also be contacted at the above-listed address or call (717) 783-5421; TDD (800) 362-4228 (for hearing impaired only).

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
WORKERS' COMPENSATION OFFICE OF ADJUDICATION

DATE OF NOTICE: 09/17/2014

NOTICE OF HEARING

WCAIS CLAIM NUMBER:

DISPUTE NUMBER:

CLAIMANT/EMPLOYEE WCID NUMBER:

INSURER CLAIM NUMBER:

INJURY DATE: 02/03/2012

PETITIONS:
Fatal Claim Petition (LIBC-363)

ASSIGNMENT WCAIS COUNTY:
Blair

Port Matilda, PA 16870-7920

State College, PA 16801-2756

vs

Plano, TX 75024-4002

William M Conwell, ESQ.
4750 US STEEL TOWER
600 GRANT STREET
PITTSBURGH, PA 15219

Philadelphia, PA 19106-3703

Lexington, KY 40512-4151

WILL HEAR PETITION (S):

DATE: 10/07/2014
TIME: 09:00 AM
DURATION: 2 Hours 40 Minutes

HEARING LOCATION:
WCOA State College Hearing Site
242
Borough of State College Municipal Building
243 South Allen Street, Room 241
State College, PA 16801-4806

EVENT DESCRIPTION:

PLEASE SEND ALL CORRESPONDENCE TO:
615 Howard Ave
Ste 202
Altoona, PA16601-4813
814-946-7355

ADJUDICATING JUDGE: Judge Robert Vonada

All proceedings are covered by the special rules of Administrative Practice & Procedure Before Judges 34 PA. Code, Chapter 131. Compliance with all rules as published will be expected of all parties.

If a party fails to appear at the scheduled hearing, the petition(s) may be disposed of on the basis of the evidence presented in the absence of that party.

VOLUNTARY MEDIATION
To request a voluntary mediation conference by a Judge, submit the request online at Http://www.dli.state.pa.us/wcais, or contact the Judge, or the office of any of the Judges listed on the website, www.dli.state.pa.us

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

STATEMENT OF WAGES (FOR INJURIES OCCURRING ON OR AFTER JUNE 24, 1996)

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

DATE OF INJURY (MM - DD - YYYY)

WCAIS CLAIM NUMBER

EMPLOYEE

First name _____

Last name _____

Date of birth _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____ Telephone _____

EMPLOYER

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

Contact _____

NAIC code _____ or Insurer code _____

Insurer/TPA claim # _____

CONCURRENT EMPLOYMENT ONLY

Check if Primary employer OR

___ Concurrent employer

INSTRUCTIONS

The Statement of Wages must be clearly completed in accordance with the Pennsylvania Workers' Compensation Act and uploaded in accordance with the provisions of the EDI Implementation guide when submitting certain EDI transactions. A copy must be sent to the injured employee.

The "average weekly wage" is used to determine the amount of weekly compensation wage-loss benefits payable under the Pennsylavania Workers' Compensation Act. A chart is available from the Bureau of Workers' Compensation to aid in determining the weekly compensation rate, online at www.dli.state.pa.us

CONCURRENT EMPLOYMENT

If the employee had more than one employer at the time of injury, a separate Statement of Wages form must be completed for each employer. Submit these forms together. Using #8 on the Primary Employer's form **only** (employer with whom the injury occurred): show the addition of the average weekly wages from all employers, show the combined average weekly wage to the right of the equal sign and show the appropriate workers' compensation rate. Check the Primary employer box for the Primary employer and the Concurrent employer box for all other employers.

Computation: Compute the appropriate items below for the employee to determine the average weekly wage.

	Wage			Weekly Board/ Lodging		Weekly Federal Reported Gratuities		Annual Bonus, Incentive or Vacation		Average Weekly Wage
1. If wages are fixed by the week:	_____		+	_____	+	_____	+	_____	= $	_____
2. If wages are fixed by the month:	_____	x 12 ÷ 52	+	_____	+	_____	+	_____	= $	_____
3. If wages are fixed by the year:	_____	÷ 52	+	_____	+	_____	+	_____	= $	_____

4. If paid in another manner, then complete the following for each of the last four consecutive periods of 13 calendar weeks preceding the injury.

	From	Through	Wages		Board/Lodging		Federal Reported Gratuities			Period Weekly Wage
1st Period	_____	_____	_____	+	_____	+	_____	÷ 13	= $	_____
2nd Period	_____	_____	_____	+	_____	+	_____	÷ 13	= $	_____
3rd Period	_____	_____	_____	+	_____	+	_____	÷ 13	= $	_____
4th Period	_____	_____	_____	+	_____	+	_____	÷ 13	= $	_____
							(Sum of three highest periods)		= $	_____

Annual bonus, incentive and vacation $ _____ ÷ 52 = $ _____ (Weekly bonus, etc) Average Weekly Wage

Sum of the highest three period weekly averages = $ _____ ÷ 3 + $ _____ (Weekly bonus, etc) = $ _____

5. If the employee has not been employed by the employer for at least three consecutive periods of 13 calendar weeks in the 52 weeks preceding the injury, use #4 above and put in the wages for any completed periods(s) of 13 weeks immediately preceding the injury and average the total amounts ..... = $ _____

6. If the employee worked less than a complete period of 13 calendar weeks and does not have fixed weekly wages: hourly wage rate $_____ x the number of hours the employee was expected to work per week under the terms of employment _____ =$ _____ + weekly board/lodging of $ _____ + weekly federal reported gratuities $_____ + (annual bonus, incentive or vacation pay ÷ 52) $ _____ ..... = $ _____

7. For seasonal occupations, the average weekly wage is one-fiftieth of the total wages earned from all occupations during the 12 months immediately preceding the injury. Twelve months prior earnings $_____ ÷ 50 = $ _____ + weekly board/lodging $_____ + weekly federal reported gratuities $_____ ..... = $ _____

8. If the calculation in #7, or any other calculation above, does not fairly ascertain the earnings of the employee, the period of calculation is extended to give a fair calculation of their average weekly wage. Show this calculation here **OR** use the space below to show calculations for concurrent employment. = $ _____

_____

COMPENSATION PAYABLE PER WEEK: = $ _____

_____ _____

Employer/Defendant Representative's signature Employer/Defendant Representative's name (typed/printed)

_____

Telephone

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services	**Claims Information Services**	**Hearing Impaired**	**Email**
717.772.3702	toll-free inside PA: 800.482.2383 local & outside PA: 717.772.4447	toll-free inside PA TTY: 800.362.4228 local & outside PA TTY: 717.772.4991	ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

EMPLOYEE REPORT OF WAGES AND PHYSICAL CONDITION

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

DATE OF INJURY (MM - DD - YYYY)

WCAIS CLAIM NUMBER

EMPLOYEE

First name _____

Last name _____

Date of birth _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____

EMPLOYER

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

NAIC code _____ or Insurer code _____

Insurer/TPA claim # _____

FAILURE TO COMPLETE THIS FORM MAY SUBJECT YOU TO ARTICLE XI OF THE WC ACT RELATING TO FRAUD.

YOU MUST COMPLETE AND RETURN THIS FORM WITHIN 30 DAYS OF BEGINNING EMPLOYMENT OR SELF-EMPLOYMENT

1. Are you now employed? ☐ Yes ☐ No
2. Are you now self-employed? ☐ Yes ☐ No
3. Have you been employed or self-employed at any time while receiving workers' compensation benefits? ☐ Yes ☐ No
   If you answered yes to one of the questions, please complete the following:

   Occupation(s): _____
4. Has your physical condition (caused by your work injury) changed? ☐ Yes ☐ No
   If yes, attach medical report.
5. Is there any other information you are aware of that is relevant in determining your entitlement to, or amount of compensation?
   ☐ Yes ☐ No

   If yes, please explain:

   _____

   _____

(OVER)

6. Names of employers for whom you have worked since your date of injury:

Name ______
Address ______
Address ______
City/Town ______ State ____ ZIP ______
Period of employment:
From ☐☐ - ☐☐ - ☐☐☐☐
MM DD YYYY
To ☐☐ - ☐☐ - ☐☐☐☐
MM DD YYYY
Amount of wages $ ______ . ____

Name ______
Address ______
Address ______
City/Town ______ State ____ ZIP ______
Period of employment:
From ☐☐ - ☐☐ - ☐☐☐☐
MM DD YYYY
To ☐☐ - ☐☐ - ☐☐☐☐
MM DD YYYY
Amount of wages $ ______ . ____

Name ______
Address ______
Address ______
City/Town ______ State ____ ZIP ______
Period of employment:
From ☐☐ - ☐☐ - ☐☐☐☐
MM DD YYYY
To ☐☐ - ☐☐ - ☐☐☐☐
MM DD YYYY
Amount of wages $ ______ . ____

IF SELF-EMPLOYED

From ☐☐ - ☐☐ - ☐☐☐☐
MM DD YYYY
To ☐☐ - ☐☐ - ☐☐☐☐
MM DD YYYY
Amount of wages $ ______ . ____

I verify that this information is true and correct based upon my knowledge, information and belief. I understand false statements are subject to the penalties of 18 Pa. C.S. §4904 relating to unsworn falsification to authorities.

Employee

First name ______
Last name ______
Signature ______

DATE OF NOTICE
☐☐ - ☐☐ - ☐☐☐☐
MM DD YYYY

Section 311.1(A) of the Workers' Compensation Act requires employees who are receiving workers' compensation, or who have filled a petition to receive workers' compensation, to report earnings from employment or self-employment. You must complete and return this form to the sender within thirty (30) days of beginning such employment or self-employment.

EMPLOYEE IS TO RETURN THIS COMPLETED FORM TO THE INSURER OR THIRD PARTY ADMINISTRATOR SHOWN ON THE FRONT.

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

EMPLOYEE VERIFICATION OF EMPLOYMENT, SELF-EMPLOYMENT OR CHANGE IN PHYSICAL CONDITION

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER ☐☐☐ - ☐☐ - ☐☐☐☐ ☐☐☐☐☐☐☐☐☐

DATE OF INJURY ☐☐ - ☐☐ - ☐☐☐☐ (MM DD YYYY)

WCAIS CLAIM NUMBER ☐☐☐☐☐☐☐

EMPLOYEE

First name _____

Last name _____

Date of birth _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____

EMPLOYER

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

NAIC code _____ or Insurer code _____

Insurer/TPA claim # _____

INSTRUCTIONS TO EMPLOYEE:

DO NOT RETURN THIS FORM TO THE BUREAU OF WORKERS' COMPENSATION.

COMPLETED FORM MUST BE RETURNED TO THE PARTY WHO SENT THE FORM TO YOU WITHIN 30 DAYS OF YOUR RECEIPT OF THIS FORM.

IF YOU DO NOT COMPLETE AND RETURN THIS FORM TO THE PARTY WHO SENT IT TO YOU WITHIN 30 DAYS IT MAY RESULT IN A SUSPENSION OF YOUR COMPENSATION BENEFITS AS PROVIDED BY SECTION 311.1(g) OF THE WC ACT, AS WELL AS PROSECUTION FOR FRAUD UNDER ARTICLE XI OF THE WC ACT.

YOU MAY BE REQUIRED TO COMPLETE AND RETURN THIS FORM EVERY SIX MONTHS.

INSTRUCTIONS TO EMPLOYEE: Section 311.1(d) of the Workers' Compensation Act requires employees who are receiving workers' compensation, or have filed a petition to receive workers' compensation, to verify employment, self-employment, wages and changes to physical condition.

1. Are you currently employed by any employer other than the employer listed above? ☐ Yes ☐ No

2. Are you currently self-employed? ☐ Yes ☐ No

3. Have you been employed or self-employed at any time while receiving workers' compensation benefits? ☐ Yes ☐ No

4. Has your physical condition (caused by your injury) changed? ☐ Yes ☐ No

5. Is there other information you are aware of that is relevant in determining your entitlement to, or amount of compensation? ☐ Yes ☐ No

(OVER)

6. Names of employers for whom you have worked since your date of injury:

Name ______________________________
Address ______________________________
Address ______________________________
City/Town ______________ State ____ ZIP __________
Period of employment:
From [ ][ ] - [ ][ ] - [ ][ ][ ][ ]
MM DD YYYY
To [ ][ ] - [ ][ ] - [ ][ ][ ][ ]
MM DD YYYY
Amount of wages $ __________ . ____

Name ______________________________
Address ______________________________
Address ______________________________
City/Town ______________ State ____ ZIP __________
Period of employment:
From [ ][ ] - [ ][ ] - [ ][ ][ ][ ]
MM DD YYYY
To [ ][ ] - [ ][ ] - [ ][ ][ ][ ]
MM DD YYYY
Amount of wages $ __________ . ____

Name ______________________________
Address ______________________________
Address ______________________________
City/Town ______________ State ____ ZIP __________
Period of employment:
From [ ][ ] - [ ][ ] - [ ][ ][ ][ ]
MM DD YYYY
To [ ][ ] - [ ][ ] - [ ][ ][ ][ ]
MM DD YYYY
Amount of wages $ __________ . ____

IF SELF-EMPLOYED

From [ ][ ] - [ ][ ] - [ ][ ][ ][ ]
MM DD YYYY
To [ ][ ] - [ ][ ] - [ ][ ][ ][ ]
MM DD YYYY
Amount of wages $ __________ . ____

I verify that this information is true and correct based upon my knowledge, information and belief. I understand false statements are subject to the penalties of 18 Pa. C.S. §4904 relating to unsworn falsification to authorities.

Employee

First name ______________________________
Last name ______________________________
Signature ______________________________

DATE OF NOTICE
[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
MM DD YYYY

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
toll-free inside PA TTY: 800.362.4228
local & outside PA TTY: 717.772.4991

Email
ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 S. CAMERON STREET, ROOM 103
HARRISBURG PA 17104-2501
(TOLL FREE; 800-482-2383

NOTICE OF SUSPENSION FOR FAILURE TO RETURN FORM LIBC-760

(EMPLOYEE VERIFICATION OF EMPLOYMENT, SELF-EMPLOYMENT OR CHANGE IN PHYSICAL CONDTION)

Social Security Number: _____ - _____ - _____

Date of Injury: ____/____/____ (MM DD YYYY)

PA BWC Claim Number: _____ (IF KNOWN)

Employee

First Name | Last Name

Street 1

Street 2

City/Town | State | Zip Code

County | Telephone ( )

Employer

Name

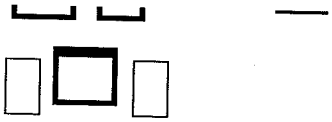
Street 1

Street 2

City/Town | State | Zip Code

County

Telephone ( ) | FEIN



762 1297-1

Insurer or Third Party Administrator (if self-insured)

Name

Street 1

Street 2

City/Town | State | Zip Code

Telephone ( ) | Bureau Code

County

Claim Number | FEIN

DATE OF THIS NOTICE: ____/____/____ (MM DD YYYY)

Attorney for Employee (if known)

Name

Firm Name

Street 1

Street 2

City/Town | State | Zip Code

Telephone ( ) | PA Attorney ID Number

Attorney for Insurer/Employer (if known)

Name

Firm Name

Street 1

Street 2

City/Town | State | Zip Code

Telephone ( ) | PA Attorney ID Number

Claim Representative

First Name | Last Name

Signature

Telephone ( )

A COPY OF THIS FORM AND ATTACHMENTS ARE TO BE PROVIDED TO THE EMPLOYEE, THE EMPLOYEE'S ATTORNEY (IF KNOWN), AND THE ORIGINAL MUST BE MAILED TO PENNSYLVANIA DEPARTMENT OF LABOR AND INDUSTRY, BUREAU OF WORKERS' COMPENSATION, AT THE ADDRESS SHOWN ABOVE.

(OVER)

You are hereby notified that your workers' compensation benefits have been suspended as of ____/____/____ due to your failure to return the *Employee Verification of Employment, Self-Employment or Change in Physical Condition* form (LIBC-760) which was mailed to you on ____/____/____ This form was due for return to the sender within 30 calendar days of its receipt. Your failure to return the completed form within this time period entities your insurer/employer to suspend your workers' compensation benefits under Section 31 1.1 (g) of the Pennsylvania Workers' Compensation Act.

Your workers' compensation benefits will immediately begin again upon your insurer/employer's receipt of the verification form, but you will not receive reinstated benefits for the period of this suspension. In addition, failure to comply with the provisions of Section 31 1.1 (d) may subject you to prosecution under the provisions of Article XI of the Pennsylvania Workers' Compensation Act relating to fraud.

If you did return the completed LIBC-760 within the prescribed time period, contact the forms sender (insurer/employer) immediately to clarify this matter.

Attached is another copy of the Employee Verification form to assure that you have the opportunity to complete and return it promptly to stop this suspension action.

You may challenge the suspension on legal grounds by filing a *Petition for Reinstatement with* the Pennsylvania Bureau of Workers' Compensation at the address listed on the front. Petitions can be obtained by calling the Bureau at **1-800-482-2383.**

Any individual filing misleading or incomplete information knowingly and with intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties through Pennsylvania Act 165 of 1994.

Attachment: Employee Verification Form LIBC-760

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

NOTICE OF ABILITY TO RETURN TO WORK

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

DATE OF INJURY (MM - DD - YYYY)

WCAIS CLAIM NUMBER

EMPLOYEE

First name _____

Last name _____

Date of birth _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____

EMPLOYER

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

NAIC code _____ or Insurer code _____

Insurer/TPA claim # _____

DATE OF NOTICE (MM - DD - YYYY)

Section 306(b)(3) of the Pennsylvania Workers' Compensation Act requires insurers to notify the employee when they receive medical evidence indicating the ability to return to work in some capacity.

Receipt of medical evidence indicates your present physical condition or change of condition is:

_____

_____

_____

_____

_____

_____

Attached are all documents supporting these allegations.

YOU SHOULD ALSO KNOW

You have an obligation to look for available employment.
Proof of available employment may jeopardize your right to receive ongoing benefits.
You have the right to consult with an attorney in order to obtain evidence to challenge the insurer's contributions.

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
toll-free inside PA TTY: 800.362.4228
local & outside PA TTY: 717.772.4991

Email
ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

LIBC-757 REV 09-13

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

NOTIFICATION OF SUSPENSION OR MODIFICATION PURSUANT TO §§ 413 (c) & (d)

DATE OF NOTIFICATION
MM - DD - YYYY

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

DATE OF INJURY
MM - DD - YYYY

WCAIS CLAIM NUMBER

EMPLOYEE

First name _____
Last name _____
Date of birth _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____
County _____
Telephone _____

EMPLOYER

Name _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____
County _____
Telephone _____ FEIN _____

INSTRUCTIONS

This form must be completed, notarized and either uploaded in WCAIS or mailed to the Bureau of Workers' Compensation (BWC), 1171 South Cameron Street, Room 103, Harrisburg, PA 17104-2501. This form must be mailed to the employee and filed with BWC within seven days of a suspension or modification of benefits under the provisions of the Workers' Compensation Act.

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____
County _____
Telephone _____ FEIN _____
NAIC code _____ or Insurer code _____
Insurer/TPA claim # _____

You are notified that because you returned to work on MM - DD - YYYY, your weekly disability benefits for this injury have been:

☐ Suspended effective MM - DD - YYYY because you have returned to work at earnings equal to or greater than your time-of-injury earnings of $_____.

OR

☐ Modified to the rate of $_____ per week, effective MM - DD - YYYY because you returned to work at earnings less than your time-of-injury earnings.

INSURER'S AFFIDAVIT

I attest or affirm that the statements contained herein are true and correct to the best of my knowledge, information and belief.

affix seal here

_____
Claims representative's signature

_____
Claims representative's name (typed/printed)

_____
Phone number

SUBSCRIBED AND SWORN TO (OR AFFIRMED) BEFORE ME THIS _____ DAY OF _____, _____

_____
Signature of notary

NOTE TO EMPLOYEE: If you do not agree with this action and wish to challenge it, please read the instructions under EMPLOYEE CHALLENGE on the back of this form.

Weekly wages must be computed in accordance with the Pennsylvania Workers' Compensation Act.

CALCULATION for partial compensation rate (to be completed for modification). The employee's new partial compensation rate is based on the claimant's present weekly earning and is calculated as follows:

Calculation: _____ Average weekly wage at time of injury

minus: _____ Present weekly earnings

_____ Subtotal

x 2/3 = _____ New partial compensation rate
(Subject to the maximum benefit)

EMPLOYEE CHALLENGE:

If you do not agree with this action, you must challenge it within (20) days of the date you receive this notice. Challenge it online at www.WCAIS.pa.gov. Choose file petition action, choose challenge and the claim number you want to challenge. In the alternative, you may challenge by checking the box below, signing this form and mailing it to the Pennsylvania Department of Labor & Industry, Workers' Compensation Office of Adjudication (WCOA), 1010 N 7th Street, Suite 201, Harrisburg, PA 17102-1400. This material must be filed with the (WCOA) within (20) days from the date you received it.

If you do not challenge this action within (20) days of the date you receive this notice, you will be deemed to have admitted that you agree with the action taken on this form. In that case, this notice will have the same binding effect as a fully executed Supplemental Agreement for the suspension or modification of benefits.

☐ I do not agree with the action taken by my employer. I request a special supersedeas hearing (a hearing on whether my workers' compensation benefits can be reduced or stopped) before a Workers' Compensation Judge. A hearing is requested to be conducted in accordance with Sections 413 (c) & (d) of the Pennsylvania Workers' Compensation Act.
(if the employee has legal counsel, complete below.)

Attorney's name _____

PA attorney ID# _____

Name of firm _____

Address _____

Address _____

City/Town _____ State ___ ZIP _____

Telephone _____

Employee's signature _____

Address _____

Address _____

City/Town _____ State ___ ZIP _____

County _____

Telephone _____
(Employee to complete if different from information provided by employer)

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

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717.772.3702

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local & outside PA: 717.772.4447

Hearing Impaired
toll-free inside PA TTY: 800.362.4228
local & outside PA TTY: 717.772.4991

Email
ra-li-bwc-helpline@pa.gov

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Equal Opportunity Employer/Program

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

SUPPLEMENTAL AGREEMENT FOR COMPENSATION FOR DISABILITY OR PERMANENT INJURY

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

DATE OF INJURY (MM - DD - YYYY)

WCAIS CLAIM NUMBER

EMPLOYEE

First name _____

Last name _____

Date of birth _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____

EMPLOYER

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

Contact _____

NAIC code _____ or Insurer code _____

Insurer/TPA claim # _____

INJURY INFORMATION

Part of body injured _____

Nature of injury

Accident/injury description narrative

Check if occupational disease ☐

NOTICE: Agreement should be clearly completed, (preferably typed) and uploaded in accordance with the provisions of the EDI Implementation Guide. A copy must be sent to the employee. Weekly wages must be completed in accordance with the Pennsylvania Workers' Compensation Act.

Whereas, the undersigned employer and employee hereby agree that the status of the employee's disability changed on (MM - DD - YYYY) as follows:

- ☐ Suspended, returned to work, no loss of wages | Termination
- ☐ Modification | Recurred
- ☐ Specific loss

Said employer shall pay employee compensation at the rate of $ _____ per week beginning on (MM - DD - YYYY)

Compensation is payable for _____ weeks _____ days; or, if the future period of disability is uncertain, then to continue at said-rate until further changed by supplemental agreement, final receipt, or order of a Workers' Compensation Judge, or the Workers' Compensation Appeal Board.

The employee's new partial compensation is based on the employee's present weekly earnings and is calculated as follows:

Calculation: _____ Average weekly wage at time of injury

Minus: _____ Present weekly earnings

_____ Subtotal

x 2/3= _____ New partial compensation rate (subject to the maximum benefit)

Further matters agreed upon (list any previously unreported periods of compensation and/or actions in chronological order, as well as additional information):

We, the undersigned, agree upon the matters represented herein by the above named employee and the above named employer.

_____
Employee's signature

Date of agreement
MM - DD - YYYY

_____
Claims Representative's signature

_____
Claims Representative's name (typed/printed)

Telephone _____

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Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
toll-free inside PA TTY: 800.362.4228
local & outside PA TTY: 717.772.4991

Email
ra-li-bwc-helpline@pa.gov

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COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 S. CAMERON STREET, ROOM 103
HARRISBURG PA 17104-2501
(TOLL FREE) 800-482-2383

NOTICE OF CHANGE OF WORKERS' COMPENSATION DISABILITY STATUS

Social Security Number: _____ - _____ - _____

Date of Injury: ____/____/_____ (MM DD YYYY)

PA BWC Claim Number: _____ (IF KNOWN)

Employee

First Name _____ Last Name _____

Street 1 _____

Street 2 _____

City/Town _____ State ____ Zip Code _____

County _____ Telephone (____)____-_____

Employer

Name _____

Street 1 _____

Street 2 _____

City/Town _____ State ____ Zip Code _____

County _____

Telephone (____)____-_____ FEIN _____

764 1297-1

DATE OF THIS NOTICE: ____/____/_____ (MM DD YYYY)

Insurer or Third Party Administrator (if self-insured)

Name _____

Street 1 _____

Street 2 _____

City/Town _____ State ____ Zip Code _____

Telephone (____)____-_____ Bureau Code _____

County _____

Claim Number _____ FEIN _____

Attorney for Employee (if known)

Name _____

Firm Name _____

Street 1 _____

Street 2 _____

City/Town _____ State ____ Zip Code _____

Telephone (____)____-_____ PA Attorney ID Number _____

Attorney for Insurer/Employer (if known)

Name _____

Firm Name _____

Street 1 _____

Street 2 _____

City/Town _____ State ____ Zip Code _____

Telephone (____)____-_____ PA Attorney ID Number _____

SEE IMPORTANT INFORMATION ON REVERSE.

Claim Representative

First Name _____ Last Name _____

Telephone (____)____-_____

This notice should be clearly completed (preferably typed) and original mailed to the Bureau at the address in the upper left corner. A copy must be sent to the employee and the employee's counsel (if known).

(OVER)

As a result of an impairment rating evaluation (examination), your disability status has changed.

A change in disability status does not affect the amount of money you receive in your workers' compensation check. Partial disability status does, however, have a maximum period of 500 weeks of benefits.

The specifics of this change are listed as follows:

Claimant Name: _____

Social Security Number: _____-_____-_____

Date of Injury: ____/____/_____
MM DD YYYY

Date you reached a total of 104 weeks of total disability: ____/____/_____
MM DD YYYY

Date initially established for the examination: ____/____/_____
MM DD YYYY

Actual Date of the Rating Examination: ____/____/_____
MM DD YYYY

Impairment Examining Physician: _____

Impairment Rating Percentage: _____%

This rating evaluation was conducted in accordance with Section 306(a.2) of the Pennsylvania Workers' Compensation Act.

☐ The above referenced Impairment Rating percentage has been used by your Insurance Carrier/Employer to change your workers' compensation status from total disability to partial disability status.

The effective date of this status change is ____/____/_____ (This effective date will be recorded on your claim record 60 days following the date of this notice)
MM DD YYYY

- OR -

☐ The result of this rating evaluation is that no change is occurring in your disability status.

You may appeal an adjustment in your workers' compensation status to a Workers' Compensation Judge by filing a *Petition for Review* with the Bureau of Workers' Compensation, 1171 S. Cameron Street, Room 103, Harrisburg, PA 17104-2501, which must include a qualified impairment rating physician's determination of impairment which is equal to or greater than 50%. If you have a question regarding this notice, please call or write the representative below.

Insurer/Employer Representative

First Name	Last Name
Signature	
Street 1	
Street 2	
City/Town	State Zip Code
Telephone (____)____-_____	Bureau Code

Any individual filing misleading or incomplete information knowingly and with intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties through Pennsylvania Act 165 of 1994.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 S. CAMERON STREET, ROOM 103
HARRISBURG PA 17104-2501
(TOLL FREE) 800-482-2383

APPLICATION FOR SUPERSEDEAS FUND REIMBURSEMENT

Social Security Number: ____-____-____

Date of Injury: ____/____/____ (MM DD YYYY)

PA BWC Claim Number: _____ (IF KNOWN)

This application is filed on behalf of: ☐ Insurer ☐ Self-Insured Employer

Employee

First Name _____ Last Name _____

Employer

Name
Street 1
Street 2
City/Town State Zip Code
County FEIN
Telephone
( )

SEE INSTRUCTIONS ON REVERSE.

662 0707

Insurer or Third Party Administrator (if self-insured)

Name
Street 1
Street 2
City/Town State Zip Code
County FEIN
Telephone
( )
Claim Number

TO THE DEPARTMENT OF LABOR AND INDUSTRY, BUREAU OF WORKERS' COMPENSATION:

As insurer in the above case, we herewith request reimbursement of compensation paid to claimant pursuant to Section 443 of the Pennsylvania Workers' Compensation Act.

IN SUPPORT OF THE ABOVE REQUEST, WE OFFER THE FOLLOWING FACTS:

Request for supersedeas was filed on ____/____/____ (MM DD YYYY) in connection with ☐ petition or ☐ appeal filed on ____/____/____ (MM DD YYYY) for ☐ termination ☐ modification ☐ suspension of compensation as of ____/____/____ (MM DD YYYY).

Insurer's/self-insurer's request for supersedeas was
☐ granted on ____/____/____ (MM DD YYYY)
☐ denied on ____/____/____ (MM DD YYYY)
☐ not acted on (and therefore deemed denied)

as a result of which insurer continued payment of compensation from ____/____/____ (MM DD YYYY) until the final outcome of the proceedings on ____/____/____ (MM DD YYYY), at which time it was determined that such compensation was not, in fact, payable.

Is there a potential or existing third-party action? ☐ Yes ☐ No If yes, list docket number _____ (if known).

Insurer/self-insurer verifies that the underlying case is not on appeal, that the appeal period has expired, and there is no other litigation pending which would affect Supersedeas Fund Reimbursement. Insurer/self-insurer affirmatively states that the decision issued by

_____ dated ____/____/____ (MM DD YYYY) is final.

(OVER)

U

INSURER, THEREFORE, REQUESTS REIMBURSEMENT OF ITS OVERPAYMENT OF COMPENSATION AS FOLLOWS:

Compensation attributable to and subsequently paid for, _____ weeks and _____ days from ____/____/____ (MM DD YYYY)

to ____/____/____ (MM DD YYYY) Inclusive at: $_____ per week for TOTAL OF $ _____. During the above time period, medical payments were incurred, and subsequently paid, for a total of $_____. Proof of payment of the above averments are attached hereto. The following unusual payment circumstances, if any, are: _____

Other matters alleged: _____

VERIFICATION

I UNDERSTAND THAT FALSE STATEMENTS HEREIN ARE MADE SUBJECT TO THE PENALTIES OF 18 PA. C.S. §4904 RELATING TO UNSWORN FALSIFICATION TO AUTHORITIES.

Submitter

Name _____

Title _____

Signature _____

Attorney for/Representative of _____

INSTRUCTIONS

All requests for reimbursement from the Supersedeas Fund pursuant to Article IV, Section 443, of the Pennsylvania Workers' Compensation Act (Act) must be by application on Form LIBC-662, Application for Supersedeas Fund Reimbursement. The Application must be fully completed, including all dates requested. Applicants must verify that the parties have not filed an appeal, and that the decision is final.

Any information that supports the Application, including underlying petitions and decisions, must be attached to the Application. Any information relating to a potential or existing third-party recovery (including but not limited to the third party settlement agreement), compromise and release agreement, or other matter which may affect this application, must also be attached. The claimant's social security number, BWC Claim Number (if known) and name must be included on each attached page.

Applicant also must file proof of payment, which must be attached to the Application. Proof of payment should be in the form of copies of canceled checks or computer printouts of payment records. Also, proof of payment must include dates of service for indemnity and medical expenses incurred and payee names.
Failure to fully complete the Application or to attach the required supporting documentation and proof of payment will result in the Application being returned without processing.

An Application may be assigned to a Workers' Compensation Judge for a hearing and determination of eligibility for reimbursement pursuant to the Act.

Any individual filing misleading or incomplete information knowingly and with intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties through Pennsylvania Act 165 of 1994.

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

THIRD PARTY SETTLEMENT AGREEMENT

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

DATE OF INJURY (MM - DD - YYYY)

WCAIS CLAIM NUMBER

EMPLOYEE

First name _____

Last name _____

Date of birth _____

If deceased - Dependent/Guardian/Personal Representative

First name _____

Last name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____ Telephone _____

NOTICE: Agreement should be clearly completed (preferably typed) and uploaded in accordance with the provisions of the EDI Implementation Guide. A copy must be sent to the employee.

EMPLOYEE'S ATTORNEY

Name _____

Firm name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

Telephone _____

PA Attorney ID number _____

EMPLOYER

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

Contact _____

NAIC code _____ or Insurer code _____

Insurer/TPA claim # _____

INSURER'S ATTORNEY

Name _____

Firm name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

Telephone _____

PA Attorney ID number _____

CALCULATION INSTRUCTIONS

#1 -- Enter the total amount of money received by the employee from the third-party litigation.
#2 -- Enter the total amount of indemnity and medical benefits paid by the employer to the employee at the time of third-party recover.
#3 -- Enter attorney fees and other expenses paid by the employee to obtain recovery in the third-party action.
#4 to #8 -- Perform the calculations in the right column and enter the results into the center column.

In accordance with section 319 of the Pennsylvania Workers' Compensation Act, the parties herein have agreed to the following distribution of proceeds received from _____, third party.

BASIC RECOVERY INFORMATION — Complete this section for all third-party settlements.

1.	Total amount of third-party recovery	1. _____		
2.	Accrued workers' compensation lien	2. _____		
	a. indemnity benefits			
	b. medical benefits			
3.	Expenses of recovery	3. _____		
4.	Balance of recovery	4. _____	_____	= #1 (minus) #2

PRESENT DISTRIBUTION OF PROCEEDS — Complete this section to calculate the amount of proceeds the employer is to receive as of _____(date through which accrued workers compensation lien [#2] calculated).

5.	Accrued lien expense reimbursement rate	5. _____ %	_____	= #2 (divided by) #1 x 100
6.	Expenses attributable to accrued lien	6. _____	_____	= #3 (times) #5
7.	Net lien (amount employer to receive)	7. _____	_____	= #2 (minus) #6

FUTURE DISTRIBUTION OF PROCEEDS — Complete this section to calculate how much the employer must reimburse the employee for expenses used to acquire the third party recovery on future compensation liability. **Note: This section is to be completed only if the total amount of the third-party recovery (#1) is greater than the amount of the accrued workers' compensation lien (#2).**

8.	Reimbursement rate on future compensation liability	8. _____ %	_____	= #3 (divided by) #1 x 100

9. The employer/insurer is responsible for _____ percent (#8) of any future weekly benefits and medical expenses to satisfy its obligation to reimburse its pro rata share of employee's fees and expenses until the subrogation interest is exhausted; _____ (#4). Thereafter, the employer/insurer is responsible for 100 percent of any compensation liability.

Further Matters Agreed Upon:

Date of this agreement
☐☐ - ☐☐ - ☐☐☐☐
MM DD YYYY

_____
Employer/Insurer Representative's signature

_____
Employee's signature

_____
Telephone

_____
Employee's Attorney signature

_____
Employer/Insurer Representative's Attorney's signature

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
toll-free inside PA TTY: 800.362.4228
local & outside PA TTY: 717.772.4991

Email
ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

UTILIZATION REVIEW REQUEST

The UR Request must be filled out completely (follow instructions): ALL INFORMATION IS REQUIRED.

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER ___ - ___ - ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

DATE OF INJURY MM DD YYYY

WCAIS CLAIM NUMBER

1. Filed on behalf of: ☐ Employee ☐ Insurer/Employer

2. **EMPLOYEE**

First name _____
Last name _____
Date of birth _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____
County _____

3. **EMPLOYEE ATTORNEY**

Firm name _____
First name _____
Last name _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____

4. **EMPLOYER**

Employer name _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____

5. **INSURER OR SELF INSURED TPA**

NAIC code _____ or Bureau code _____
(*Required: See BWC Website for Bureau codes)
Insurer/TPA name # _____
Insurer claim # _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____
Claim rep name _____
Claim rep telephone _____

6. **INSURER/EMPLOYER ATTORNEY**

Firm name _____
First name _____
Last name _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____

****7-10 Provider Under Review/Treatment Information**
Please see instructions

PROVIDER 1
First name _____ Last name _____
Office address _____
City _____ State _____ ZIP _____
Telephone _____ License/Specialty _____
Treatment to be reviewed:
_____
Start/End date _____ WCJ Circulation date _____
Bill rec'd _____ None ☐ Report rec'd _____ None ☐

PROVIDER 2
First name _____ Last name _____
Office address _____
City _____ State _____ ZIP _____
Telephone _____ License/Specialty _____
Treatment to be reviewed:
_____
Start/End date _____ WCJ Circulation date _____
Bill rec'd _____ None ☐ Report rec'd _____ None ☐

PROVIDER 3
First name _____ Last name _____
Office address _____
City _____ State _____ ZIP _____
Telephone _____ License/Specialty _____
Treatment to be reviewed:
_____
Start/End date _____ WCJ Circulation date _____
Bill rec'd _____ None ☐ Report rec'd _____ None ☐

PROVIDER 4
First name _____ Last name _____
Office address _____
City _____ State _____ ZIP _____
Telephone _____ License/Specialty _____
Treatment to be reviewed:
_____
Start/End date _____ WCJ Circulation date _____
Bill rec'd _____ None ☐ Report rec'd _____ None ☐

PROVIDER 5
First name _____ Last name _____
Office address _____
City _____ State _____ ZIP _____
Telephone _____ License/Specialty _____
Treatment to be reviewed:
_____
Start/End date _____ WCJ Circulation date _____
Bill rec'd _____ None ☐ Report rec'd _____ None ☐

(Pursuant to §127.404(b) the request for UR shall be filed within 30 days of receipt of the bill and report for the treatment at issue)

11. **Other Treating Providers:** If not filing electronically, please list any other treating providers for this claimant on additional sheet.
Include first and last name, license and specialty, full address and telephone number for each provider.

12. This is an Act 46 (firefighter cancer) claim ☐

13. **Proof of Service:** I hereby certify that on this day I have mailed a copy of this request to all parties and their attorneys, if known, including the provider(s) under review. ANY FALSE STATEMENT CONTAINED IN THIS UTILIZATION REVIEW REQUEST MAY BE THE SUBJECT OF PROSECUTION UNDER ARTICLE XI OF THE ACT (RELATING TO INSURANCE FRAUD), OR 18 Pa. C.S. §4903 (RELATING TO FALSE SWEARING).

14. _____ Requesting Party or Representative's signature
_____ Requesting Party or Representative's name (typed/printed)

_____ Address
_____ City State ZIP

_____ Telephone number
_____ Email address

_____ Proof of Service date (MUST be updated if request is amended/re-filed)

NOTE: If not filing electronically, send the original to: Bureau of Workers' Compensation, Medical Treatment Review Section
1171 South Cameron Street, Harrisburg, PA 17104-2597

DO NOT attach deposition, medical records, IME reports or any other document not specifically requested to the UR Request Form. Any attachments not specifically requested will NOT be forwarded to the URO, and will NOT be returned. The Bureau will destroy/shred all attachments not requested.

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
toll-free inside PA TTY: 800.362.4228
local & outside PA TTY: 717.772.4991

Email
ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program