

## CLAIM PETITION FOR BENEFITS FROM THE UNINSURED EMPLOYER AND THE UNINSURED EMPLOYERS GUARANTY FUND

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**

**AND**

|  |
|--|
| Pennsylvania Uninsured Employers Guaranty Fund<br>PO Box 1774<br>Harrisburg, PA 17105-1774 |
|--|

**Employee should file this petition if they are seeking an award against their employer and the Uninsured Employers Guaranty Fund because their employer did not maintain workers' compensation insurance coverage and was not approved as a self-insurer at the time of the alleged injury. Note: You may not file this petition until 21 days after you filed a Notice of Claim Against Uninsured Employer, Form LIBC-551.**

1. Have you filed a Notice of Claim Against the Uninsured Employer, Form LIBC-551?  Yes  No
2. Complete description of injury or illness including all parts of body affected. If fatality, provide cause of death.  
\_\_\_\_\_
3. If occupational disease, give the last date of employment 

|    |    |      |   |
|----|----|------|---|
| □  | □  | □    | □ |
| MM | DD | YYYY |   |

 and/or last date of exposure 

|    |    |      |   |
|----|----|------|---|
| □  | □  | □    | □ |
| MM | DD | YYYY |   |
4. Give date of injury or onset of disease 

|    |    |      |   |
|----|----|------|---|
| □  | □  | □    | □ |
| MM | DD | YYYY |   |
5. How did the injury or disease occur? \_\_\_\_\_
6. Did injury or disease occur on employer's premises?  Yes  No Where? (Be specific)  
\_\_\_\_\_
7. Notice of your injury or disease was served on your employer on 

|    |    |      |   |
|----|----|------|---|
| □  | □  | □    | □ |
| MM | DD | YYYY |   |

 in the following manner:  
\_\_\_\_\_
8. What was your job title at the time of injury or disease? \_\_\_\_\_
9. Were you working for more than one employer at the time of the injury?  Yes  No If yes, list additional employers:
10. Did this problem cause you to stop working?  Yes  No If yes, give date. 

|    |    |      |   |
|----|----|------|---|
| □  | □  | □    | □ |
| MM | DD | YYYY |   |
11. Are you back to work with the same employer?  Yes  No If yes,  Regular job  Other job/give title \_\_\_\_\_
12. Are you working with another employer?  Yes  No If yes, give name and address of new employer:  
\_\_\_\_\_

13. What were your weekly wages at the time of injury? \$  .

14. Dependents are as follows:

| NAME  | ADDRESS | DATE OF BIRTH<br>MM-DD-YYYY | RELATIONSHIP | US CITIZEN   |
|-------|---------|-----------------------------|--------------|--|
| _____ | _____   | _____                       | _____        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | _____   | _____                       | _____        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | _____   | _____                       | _____        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | _____   | _____                       | _____        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | _____   | _____                       | _____        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | _____   | _____                       | _____        | <input type="checkbox"/> Yes <input type="checkbox"/> No |

15. 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 weekly wages \$  .

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

- Loss of Wages
  - Partial disability from  -  -  to  -  -
  - Full disability from  -  -  to  -  -
- Medical bills (give name of doctor/hospital, address, type of treatment and bill in space below.)
- Counsel fees to be paid by the employer. (Note: The Fund is not subject to unreasonable contest attorney fees.)
- Loss or loss of use of arm, hand, finger, leg, foot or toe.
- Disfigurement (scars) of head, face or neck.
- Injury or disease resulting in death. Date of death.  -  -
- Loss of sight
- Loss of hearing
- Cancer as a firefighter under Act 46 of 2011

17. Have you filed any other Workers' Compensation Petition(s) related to this injury/fatality?  Yes  No  
If yes, PA BWC Claim Number (if known) \_\_\_\_\_.

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

A copy of this petition has been sent to the employer and the Fund.

Signature \_\_\_\_\_

Employee or Dependent  Attorney

**Notice: This petition must be filled out as fully as possible. If not filling 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 of this petition to the employer and Guaranty Fund, PO Box 1774, Harrisburg, PA 17105-1774. Questions regarding the completion of this form ma be directed to 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



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