



**Medical**

Has the employee sought medical treatment for the work injury?  Yes  No

Has the employer paid for medical treatment for the work injury?  Yes  No

List Doctors/Medical Facilities and their addresses. (Attach additional sheets, if necessary.)

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The injured employee (or dependent, if the employee is deceased) must complete and sign the following authorization, which the Uninsured Employers Guaranty Fund may use to collect records relating to medical treatment that the injured or deceased employee received, and to collect wage information from the injured or deceased employee's current or previous employer(s).

**AUTHORIZATION TO RELEASE INFORMATION/VERIFICATION OR INFORMATION**

To Whom It May Concern:

By signing below, I hereby request and authorize you to furnish to the Pennsylvania Uninsured Employers Guaranty Fund or its representative(s) any and all information you have concerning the above-named employee with respect to any illness or injury, medical history, consultation, treatment, including x-rays, as well as copies of all hospital or medical records, military records or other government records.

I further request and authorize employers to furnish complete information concerning wages, commissions and the like. By signing below, I attest that I am the employee identified above, or that I am the deceased employee's dependent authorized to request the release of such records, and that I am pursuing a claim for benefits under the Pennsylvania Workers' Compensation Act.

A photocopy of this authorization shall be considered as effective and valid as the original authorization.

**VERIFICATION**

By signing below, I verify that all information submitted on this form is, to the best of my knowledge, information and belief, true, complete and correct. I understand that any individual who knowingly and with the intent to defraud, files misleading or incomplete information is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to civil and criminal penalties, including prosecutions under 18 Pa. C.S.A. §4903 (relating to false swearing).

Employee or dependent signature: \_\_\_\_\_

Print name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Relationship to deceased employee, if applicable: \_\_\_\_\_

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*