

AUTHORIZATION FOR ALTERNATIVE DELIVERY OF COMPENSATION PAYMENTS

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER DATE OF INJURY WCAIS CLAIM NUMBER

<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>
	MM DD YYYY	

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 # _____

DATE OF AUTHORIZATION

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
MM			DD			YYYY			

I, _____, hereby authorize and agree that the checks for the compensation payments due
 Claimant name (please print)
 to me shall be forwarded to me in the following designated manner:

- I will pick up my checks at (please check only one box): employer office insurer office
- The employer/insurer will mail my checks to me at:

- The employer/insurer will direct deposit my checks to the account at the financial institution supplied on the attached authorization for direct deposit. (Attach authorization for direct deposit provided by your financial institution.)
- Other:

I understand that my employer/insurer is required to mail my compensation checks to my last known address and that I am not under any obligation to authorize the method of delivery outlined above.

Claimant's signature

Claimant's name (typed/printed)

Employer/Insurer representative's signature

Employer/Insurer representative's name (typed/printed)

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*