

AGREEMENT FOR COMPENSATION FOR DISABILITY OR PERMANENT INJURY

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

DATE OF INJURY

WCAIS CLAIM NUMBER

- -

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 #

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*