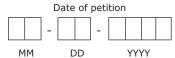
pennsylvania DEPARTMENT OF LABOR & INDUSTRY WORKERS' COMPENSATION OFFICE OF ADJUDICATION

PETITION FOR COMMUTATION

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER	DATE OF INJURY WCAIS CLAIM NUMBER
EMPLOYEE	MM DD YYYY EMPLOYER
First name	Name
Last name	Address
Date of birth	Address
Address	City/Town State ZIP
Address	County
City/Town State ZIP	Telephone FEIN
County	VS. INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)
Telephone	Name
INJURY INFORMATION	Address
Provide the following information if Employer has accepted	Address
liability for this injury:	City/Town State ZIP
Part of body injured	County
Nature of injury	Telephone FEIN
	Contact
Accident/injury description narrative	NAIC code or Insurer code
	Insurer/TPA claim #
Check if occupational disease	
Compensation Presently Payable Under: Notice of	Compensation Payable Agreement
	ental Agreement Award
TO YOUR HONORABLE JUDGE:	
Ι,	employee dependent or guardian employer
hereby petitions your honorable Judge to commute the sum of \$	representing future installments of
compensation payable in the captioned case, as provided under S	Section 316 of the Pennsylvania Workers' Compensation Act,
and to order payment of said compensation in one lump sum to	at its then value discounted
at five (5) percent interest for the following reasons:	

PLEASE ENTER MY APPEARANC	E FOR PETITIONER:	
Attorney's name		
PA Attorney ID number		
Firm name		
Address		
Address		
City/Town		
Telephone		

Petitioner or Representative's signature



Petitioner or Representative's name (typed/printed)

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 to 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 PA Relay 7-1-1 **Email** ra-li-bwc-helpline@pa.gov



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