

ANSWER TO PETITION FOR COMMUTATION

EMPLOYEE First name Last name Date of birth Address Address City/Town County Telephone INJURY INFORMATION Provide the following information if Employer has accepted liability for this injury: Part of body injured Nature of injury Accident/injury description narrative Accident/injury description narrative MM DD YYYYY EMPLOYER Name Address Address City/Town State ZIP County Telephone FEIN County Address City/Town State ZIP County Telephone FEIN County Telephone FEIN Contact NAIC code Insurer/TPA claim #
First name
First name
Last name
Date of birth
Address
Address County Telephone FEIN
City/Town State ZIP
County
Telephone
INJURY INFORMATION Provide the following information if Employer has accepted liability for this injury: Part of body injured
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Part of body injured
Nature of injury
Accident/injury description narrative Telephone FEIN NAIC code or Insurer code
Accident/injury description narrative NAIC code or Insurer code
Accident/injury description narrative
Accident/injury description narrative Insurer/TPA claim #
Check if occupational disease
Compensation Presently Payable Under: Notice of Compensation Payable Supplemental Agreement Award
TO YOUR HONORABLE JUDGE:
In answer to the petition presented to your Honorable Judge by
requesting commutation of future installments of compensation payable in the captioned case, (I)(we) submit for your consideration the following facts:

(I)(we) further submit for	your consideration the following addit	ional facts:	
For the above reasons, (I) commutation in the captio		ge	the said petition for
WHEREFORE, the respond	ent requests that the petition be dismi	ssed or in the alternative disallowed.	
attached. A Proof of Service is a s	signed statement signed by you verifying that yo	or all other parties which are represented by couns u have sent a copy of the petition to all parties and no the completion of this form may be directed to the	their attorneys, if known. Answers
	RANCE FOR RESPONDENT:		
Attorney's name			
			Date filed
	State ZIP .		DD YYYY
Telephone			
Attorney's signature		Attorney's name (typed/printed)	
Respondent's signature		Respondent's name (typed/printed)	
	ncomplete information knowingly and with the inte subject to criminal and civil penalties under 18 Pa.	ent to defraud is in violation of Section 1102 of the Pe C.S.A. §4117 (relating to insurance fraud).	nnsylvania Workers' Compensation Act
Employer Information Services	Claims Information Services toll-free inside PA: 800.482.2383	Hearing Impaired PA Relay 7-1-1	Email ra-li-bwc-helpline@pa.gov

717.772.3702

local & outside PA: 717.772.4447

