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

CLAIM PETITION FOR ADDITIONAL COMPENSATION FROM THE SUBSEQUENT INJURY FUND PURSUANT TO SECTION 306.1 OF THE WORKERS' COMPENSATION ACT

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

___ - __ - ____ _____

DATE OF INJURY

__ - __ - ____
MM DD YYYY

WCAIS CLAIM NUMBER

_____

EMPLOYEE

First name _____

Last name _____

Date of birth _____

If deceased - Dependent/Guardian/Personal Representative

First name _____

Last name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____

INJURY INFORMATION

Part of body injured _____

Nature of injury _____

_____

_____

Accident/injury description narrative _____

_____

_____

Check if occupational disease ☐

EMPLOYER

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

VS. INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

NAIC code _____ or Insurer code _____

Insurer/TPA claim # _____

AND
Commonwealth of Pennsylvania
Department of Labor & Industry
c/o Office of Chief Counsel
1171 South Cameron St
Harrisburg, PA 17104-2501

An employee seeking additional compensation from the Subsequent Injury fund should file this petition if the employee has previously incurred (through injury or otherwise) permanent partial disability, through the loss, or loss of use of, one hand, one arm, one foot, one leg or one eye, and incurs total disability through a subsequent injury, causing loss, or loss of use of, another hand, arm, foot, leg or eye.

1. Date of first (prior) loss or loss of use of, one hand, arm, foot, leg or eye, resulting in permanent partial disability.

   __ - __ - ____
   MM DD YYYY

2. Complete description of first (prior) loss or loss of use.

   a. Was this loss or loss of use work-related? ☐ Yes ☐ No If Yes, name and address of employer:

   _____

   _____

3. Date of second (subsequent) loss, or loss of use of another hand, arm, foot, leg or eye, resulting in total disability.

   __ - __ - ____
   MM DD YYYY

4. Complete description of second (subsequent) loss or loss of use injury.
   a. Was this loss of use injury work-related? ☐ Yes ☐ No If yes, name and address of employer:

   _____

   _____

5. Is there pending workers' compensation litigation or a previous Workers' Compensation Judge's decision regarding the second (subsequent) loss or loss or use injury? ☐ Yes ☐ No
   a. If yes, when was the claim petition filed? ☐☐ - ☐☐ - ☐☐☐☐ (MM DD YYYY)
   b. If a Workers' Compensation Judge's decision was rendered, what was the circulation date of the decision?
   ☐☐ - ☐☐ - ☐☐☐☐ (MM DD YYYY)
   c. Was there an award of benefits for a specific loss or loss of use? ☐ Yes ☐ No
      i. If yes, how many weeks of benefits were awarded? ☐☐☐
      ii. On what date did the specific loss award commence?
      ☐☐ - ☐☐ - ☐☐☐☐ (MM DD YYYY)

6. What were your wages at the time of the second (subsequent) injury? $ ☐☐☐☐ . ☐☐ ☐ Hour ☐ Day ☐ or Week

7. If you have returned to work since the second (subsequent) injury, are you earning than you were at the time of the injury? Current earnings $ ☐☐☐☐ . ☐☐ ☐ More ☐ Same ☐ Less ☐ Hour ☐ Day ☐ or Week

8. Are you entitled to receive any other benefits by reason of your increased disability, either from any state or federal fund or agency? ☐ Yes ☐ No If yes, please list.

PLEASE ENTER MY APPEARANCE FOR PETITIONER:

Attorney's name _____
PA Attorney ID number _____
Firm name _____
Address _____
Address _____
City/Town _____ State _____ ZIP _____
Telephone _____

Date of petition
☐☐ - ☐☐ - ☐☐☐☐ (MM DD YYYY)

_____
Attorney's signature

Notice: This petition must be filled out as fully as possible. The original must be sent to the Workers' Compensation Office of Adjudication, 1010 N. Seventh St, Suite 202, Harrisburg, PA, 17102-1400. You must serve a copy on all other parties, and on 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	**Claims Information Services**	**Hearing Impaired**	**Email**
717.772.3702	toll-free inside PA: 800.482.2383 local & outside PA: 717.772.4447	toll-free inside PA TTY: 800.362.4228 local & outside PA TTY: 717.772.4991	ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program