

OCCUPATIONAL DISEASE CLAIM PETITION  
MONTHLY COMPENSATION FOR  
DISABILITY UNDER SECTION 301(i) ONLY

**EMPLOYEE**

First name \_\_\_\_\_  
 Last name \_\_\_\_\_  
 Date of birth \_\_\_\_\_  
 Address \_\_\_\_\_  
 Address \_\_\_\_\_  
 City/Town \_\_\_\_\_ State \_\_\_\_ ZIP \_\_\_\_\_  
 County \_\_\_\_\_  
 Telephone \_\_\_\_\_

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

**INJURY INFORMATION**

Part of body injured \_\_\_\_\_  
 Nature of injury \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Accident/injury description narrative \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Check if occupational disease

1. My last date of employment or self-employment in any occupation was   -   -    .  
MM DD YYYY

2. I became totally disabled on   -   -     as a result of:  
MM DD YYYY  
 Coal Workers' Pneumoconiosis  Silicosis  Anthraco-Silicosis  Asbestosis

3. My total disability is a result of employment in a hazardous occupation having a:  
 Coal hazard  Asbestos hazard  Silica hazard

4. I was employed in the Commonwealth of Pennsylvania at least two years preceding the above date of the disability, as follows:  
 (List all employment in the hazardous occupation.)

NAME OF EMPLOYER IN PENNSYLVANIA	ADDRESS	DATES OF EMPLOYMENT	
		FROM MM-DD-YYYY	TO MM-DD-YYYY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5. If you have filed a claim previously under the Occupational Disease Act or the Workers' Compensation Act, complete the following:

(a) Date of filing   -   -      
MM DD YYYY

(b) Claim petition:  Pending  Dismissed  Withdrawn

(c) Claim filed under:  Occupational Disease Act  Workers' Compensation Act

6. I  have  have not filed for benefits under the Federal Health and Coal Mine Safety Act of 1969.

Therefore, I hereby petition the Department of Labor & Industry to award monthly compensation to me at the rate set forth under the provisions of Section 301 (i) of the 1939 Occupational Disease Act, as amended.

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. 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 serve a copy to all other parties, and on the attorneys of all other parties, if the attorneys are known. Questions regarding the completion of this form may be directed to the Bureau of Workers' Compensation Claims Information Services.**

### INSTRUCTIONS TO CLAIMANT

Failure to comply with these instructions will necessitate the return of your petition.

Employee must **sign this document**.

Attach two recent photographs. Place your signature and last four digits of Social Security Number on the reverse side of each photograph.

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*