

NOTICE OF TEMPORARY COMPENSATION PAYABLE

EMPLOYEE

Date of birth - -

MM DD YYYY

County _____

Telephone _____

DATE OF NOTICE
 - -

MM DD YYYY

DATE OF INJURY
 - -

MM DD YYYY

SOCIAL SECURITY NUMBER
 - -

W ID NUMBER

WCAIS CLAIM NUMBER

EMPLOYER

Name _____

Address _____

Address _____

City/Town _____ State _____ ZIP _____

County _____

Telephone _____ FEIN _____

INSURER

Name _____

Address _____

Address _____

City/Town _____ State _____ ZIP _____

County _____

Telephone _____ FEIN _____

NAIC code _____ Insurer code _____

Insurer/Administrator claim # _____

TPA

Name _____

Address _____

Address _____

City/Town _____ State _____ ZIP _____

County _____

Telephone _____ FEIN _____

Insurer/Administrator claim # _____

INJURY INFORMATION

Part of body injured

Nature of injury

Accident/injury description narrative

County _____

Check if occupational disease

NOTICE TO EMPLOYEE: This notice of **temporary** compensation payments is for a period of up to 90 days and **is not** an admission by your employer that it is responsible for your injury. If any questions arise, contact the representative on the reverse side of this notice. If you need further information, call the bureau at 800-482-2383.

NOTICE TO EMPLOYER: This notice must be filed with the Bureau of Workers' Compensation via electronic format. In wage loss claims, a copy of the notice is to be sent to the injured employee with the first payment of **temporary** compensation. In wage loss claims, the 90 day period begins on the first day of disability. The employer's/insurer's failure to file a notice as provided in Section 406.1(d)(5) of the Act advising the employee that the employer is ceasing temporary compensation shall be deemed an admission of liability, and this notice shall be converted to a Notice of Compensation Payable. A separate paper copy of this EDI-generated form should not be uploaded or sent to the Bureau.

Specific information regarding this claim is on the reverse side of this form.

Compensation is payable as follows:

Check only if compensation for medical treatment (**medical only, no loss of wages**) will be paid subject to the Workers' Compensation Act. Compensation for medical treatment is payable from the date of injury. If employer stops temporary compensation in accordance with the Act, employer will not pay for treatment received on or after the stoppage date. For compensation for medical treatment only, you should not complete number 1.

1. Weekly compensation rate \$. Based on an average weekly wage of \$.

This box is checked if AWW is estimated. This box is checked if wages paid in lieu of compensation.

A Statement of Wages, Form LIBC-494A or a Statement of Wages, Form LIBC-494C must be filed with every indemnity TACP or TNCP unless wages are estimated.

Section 308 of the PA Workers' Compensation Act generally provides that compensation shall be paid in periodic installments as the wages of the employee were payable before the injury.

2. Ninety-day period begins on - - and ends on - -
MM DD YYYY MM DD YYYY

Claims representative's name _____ Telephone _____

NOTICE TO EMPLOYEE: If any questions arise regarding these payments, contact the claims representative named above.

Any intentional filing of 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

To view your claim file, log on to www.wcais.pa.gov

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