

NOTICE OF CLAIM AGAINST UNINSURED EMPLOYER

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER
 - -

DATE OF INJURY
 - -
 MM DD YYYY

WCAIS CLAIM NUMBER

Instructions: Please complete both sides of this form and upload the form, signed by the claimant in the WCAIS system. **You must complete all questions that appear in bold print or the Bureau will not accept this form and will return it to you.** Forms completed and signed by the claimant, if properly uploaded to WCAIS will constitute notice to the Fund pursuant to section 1603(b) of the Pa. Workers' Compensation Act, 77 P.S. § 2703(b). If you do not wish to upload this form via the WCAIS system, you may notify the Fund of this claim by mailing the completed notice to 1171 S. Cameron St., Room 103, Harrisburg, PA 17104-2501. A Claim Petition for Benefits From the Uninsured Employer and the Uninsured Employers Guaranty Fund, Form LIBC-550, may be filed 21 days after filing this form.

EMPLOYEE

First name _____
 Last name _____
 Date of birth _____
 Address _____
 Address _____
 City/Town _____ State ____ ZIP _____
 County _____ Telephone _____

EMPLOYER

Name _____
 Address _____
 Address _____
 City/Town _____ State ____ ZIP _____
 County _____
 Telephone _____ FEIN _____
 Owner/Contact _____

Injury

Did the injury result in a fatality? Yes No

Where did the injury occur; Address: _____

City: _____ **State:** _____

Describe the incident and injury.

Was the injury reported to the employer? Yes No **If yes, when?** _____

To whom? _____

Disability

Occupation/Job Title _____

List the employee's weekly wages at the time of injury _____

Last day worked - - **Hours worked per week** _____
 MM DD YYYY

ATTACH MOST RECENT PAY STATEMENT OR CHECK/STUB.

Did the injury cause a loss of wages? Yes No

Has the employer been paying for lost wages? Yes No

Has the employee returned to work? Yes No **If so, when?** _____

How much is the employee earning \$ _____ per hour / day / week (circle one)

For whom does the employee work? Give name, address and telephone number _____

Medical

Has the employee sought medical treatment for the work injury? Yes No

Has the employer paid for medical treatment for the work injury? Yes No

List Doctors/Medical Facilities and their addresses. (Attach additional sheets, if necessary.)

The injured employee (or dependent, if the employee is deceased) must complete and sign the following authorization, which the Uninsured Employers Guaranty Fund may use to collect records relating to medical treatment that the injured or deceased employee received, and to collect wage information from the injured or deceased employee's current or previous employer(s).

AUTHORIZATION TO RELEASE INFORMATION/VERIFICATION OR INFORMATION

To Whom It May Concern:

By signing below, I hereby request and authorize you to furnish to the Pennsylvania Uninsured Employers Guaranty Fund or its representative(s) any and all information you have concerning the above-named employee with respect to any illness or injury, medical history, consultation, treatment, including x-rays, as well as copies of all hospital or medical records, military records or other government records.

I further request and authorize employers to furnish complete information concerning wages, commissions and the like. By signing below, I attest that I am the employee identified above, or that I am the deceased employee's dependent authorized to request the release of such records, and that I am pursuing a claim for benefits under the Pennsylvania Workers' Compensation Act.

A photocopy of this authorization shall be considered as effective and valid as the original authorization.

VERIFICATION

By signing below, I verify that all information submitted on this form is, to the best of my knowledge, information and belief, true, complete and correct. I understand that any individual who knowingly and with the intent to defraud, files misleading or incomplete information is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to civil and criminal penalties, including prosecutions under 18 Pa. C.S.A. §4903 (relating to false swearing).

Employee or dependent signature: _____

Print name: _____

Address: _____

Telephone: _____

Relationship to deceased employee, if applicable: _____

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*