pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

AGREEMENT FOR COMPENSATION FOR DISABILITY OR PERMANENT INJURY

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 _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____

EMPLOYER

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

Contact _____

NAIC code _____ or Insurer code _____

Insurer/TPA claim # _____

INJURY INFORMATION

Part of body injured _____

Nature of injury _____

_____

_____

Accident/injury description narrative _____

_____

_____

Check if occupational disease ☐

NOTICE: Agreement should be clearly completed, (preferably typed) and uploaded in accordance with the provisions of the EDI Implementation Guide. A copy must be sent to the employee. Wage information must be completed in accordance with the Pennsylvania Workers' Compensation Act, and sent to the employee.

DATE DISABILITY BEGAN __ - __ - ____
MM DD YYYY

The employer shall pay the employee compensation at a rate of $ _____ per week on an average weekly wage of $ _____ beginning __ - __ - ____ .
MM DD YYYY

Date first check mailed _____. If the date exceeds the 21-Day Rule, check this box ☐
And explain under "further matters agreed upon" on reverse.

Payment of medical and hospital expenses are subject to the limits of time and amount provided by the Pennsylvania Workers' Compensation Act and subject to modification or termination with the Act.

Compensation payable for ____ weeks ____ days for loss or loss of use of _____ under Section 306(c).

Compensation payable for ____ weeks ____ days for healing period for loss or loss of use of _____ under Section 306(c).

Compensation payable for ____ weeks ____ days for disfigurement under Section 306(c). Please describe the disfigurement.

_____

_____

_____

Further matters agreed upon:

We, the undersigned, agree upon the matters represented herein by the above named employee and the above named employer.

Employee's signature

Date of agreement

MM - DD - YYYY

Claims Representative's signature

Claims Representative's name (typed/printed)

Telephone

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