

SUPPLEMENTAL AGREEMENT FOR COMPENSATION FOR DEATH

DECEASED'S SOCIAL SECURITY NUMBER OR WC ID NUMBER

- -

DATE OF INJURY

- -

MM DD YYYY

WCAIS CLAIM NUMBER

DECEASED EMPLOYEE

First name _____
 Last name _____
 Date of birth - -
 MM DD YYYY
 Date of death - -
 MM DD YYYY

EMPLOYER

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

DEPENDENT/GUARDIAN/PERSONAL REPRESENTATIVE

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

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 EDI Implementation Guide. A copy must be sent to the employee. Wage information must be completed in accordance with Section 309 of the Pennsylvania Workers' Compensation Act, and sent to the Dependent/Guardian/Personal Representative.

We, the following persons, dependents of the aforementioned deceased employee, and the undersigned employer, are parties to a compensation agreement or award which is changed because on

- -

MM DD YYYY

the dependent, _____

Died Remarried A posthumous child was born Other _____

It is now agreed that compensation shall be payable as follows:

WEEKLY RATE	FROM MM-DD-YYYY	THROUGH MM-DD-YYYY	#WEEKS/#DAYS	REASON FOR CHANGE	AMOUNT
\$ _____	_____	_____	_____	_____	\$ _____
\$ _____	_____	_____	_____	_____	\$ _____
\$ _____	_____	_____	_____	_____	\$ _____
\$ _____	_____	_____	_____	_____	\$ _____
\$ _____	_____	_____	_____	_____	\$ _____
\$ _____	_____	_____	_____	_____	\$ _____
\$ _____	_____	_____	_____	_____	\$ _____

The above compensation shall be payable from - - to - - .
MM DD YYYY MM DD YYYY

Further matters agreed upon:

Date of this agreement

- -
MM DD YYYY

 Dependent/Guardian/Personal Representative's signature

 Claims Representative's name (typed/printed)

 Claims Representative's signature

 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
 PA Relay 7-1-1

Email
 ra-li-bwc-helpline@pa.gov



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