

## AGREEMENT TO STOP WEEKLY WORKERS' COMPENSATION PAYMENTS FINAL RECEIPT

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER      DATE OF INJURY      WCAIS CLAIM NUMBER

<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
		MM      DD      YYYY	

**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 # \_\_\_\_\_

**NOTICE TO EMPLOYEE**

**Signing this form means your weekly workers' compensation payments will stop.** You may file a petition to reopen your claim within three years of the date to which payments were made.

**SIGN THIS FORM IF:** Beginning and ending dates and total amount paid shown below are correct; AND you have fully recovered from your injury or disease.

**DO NOT SIGN THIS FORM IF:** You have returned to work, but are earning less due to work related injury; OR your employer or the insurance company is withholding your last workers' compensation check unless you sign this form.

Notice: Agreement should be clearly completed (preferably typed) and uploaded in accordance with the provisions of the EDI Implementation Guide. A copy must be mailed to the employee.

The employee received from the above named EMPLOYER/INSURER the sum of \$ \_\_\_\_\_ as final payment of compensation due under the Pennsylvania Workers' Compensation Act for the injury or disease incurred in the above case. The total amount of compensation received, including the final payment above, is \$ \_\_\_\_\_ in disability benefits for wage loss covering a period of \_\_\_\_\_ weeks \_\_\_\_\_ days from the date my disability began on   -   -     until the employee was able to return to work on   -   -     without loss of earning power due to the injury or disease incurred.

**Notice: The employer/insurance company hereby agrees that no representations have been made to the employee other than those contained in this agreement and that this complies with the Workers' Compensation Act and Rules and Regulations.**

Employee's signature \_\_\_\_\_

-   -

MM      DD      YYYY

Employer/Claims Representative's signature \_\_\_\_\_

Employer/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**  
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