pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

AGREEMENT TO STOP WEEKLY WORKERS' COMPENSATION PAYMENTS FINAL RECEIPT

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 ____________________

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.

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: 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 __-__-____ (MM DD YYYY) until the employee was able to return to work on __-__-____ (MM DD YYYY) 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

____
Employer/Claims Representative's signature

__-__-____ (MM DD YYYY)

____
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