

CLAIM PETITION FOR WORKERS' COMPENSATION

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 _____
 If deceased - Dependent/Guardian/Personal Representative _____
 First name _____
 Last name _____
 Address _____
 Address _____
 City/Town _____ State ____ ZIP _____
 County _____ Telephone _____

EMPLOYER

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

VS. INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name _____
 Address _____
 Address _____
 City/Town _____ State ____ ZIP _____
 County _____
 Telephone _____ FEIN _____
 NAIC code _____ or Insurer code _____
 Insurer/TPA claim # _____

1. Complete description of injury or illness including all parts of body affected. (If you are seeking additional compensation from the Subsequent Injury Fund for total disability as a result of a previous permanent loss, or loss of use of one hand, one arm, one foot, one leg or one eye, and a subsequent injury causing loss, or loss of use of, another hand, arm, foot, leg or eye, you must also submit from LIBC-375).

2. If occupational disease, give the last date of employment - - and/or last date of exposure - - with this employer.
 MM DD YYYY
- 2a. Cancer as a firefighter under Act 46 of 2011.
3. Give date of injury or onset of disease - - .
 MM DD YYYY
4. How did the injury or disease happen?
5. Did injury or disease occur on employer's premises? Yes No Where? (Be specific)
6. Notice of your injury or disease was served on your employer on - - in the following manner:
 MM DD YYYY
7. What was your job title at the time of injury or disease? _____
8. Were you working for more than one employer at the time of your injury? Yes No If yes, list additional employers:

9. Did this problem cause you to stop working? Yes No If yes, give date - - .
MM DD YYYY

10. Are you back to work with the same employer? Yes No If yes, Regular job Other job/give title

11. Are you back to work with another employer? Yes No If yes, give name and address of new employer:

12. What were your wages at the time of injury? \$. Hour Day Week

13. If you have returned to work since your injury or illness, are you earning More Same Less
than you were at the time of injury? Current earnings \$. Hour Day Week

14. I am seeking payment for (check all that apply):

Partial disability from - - thru - - (date disability ends) or ongoing.
MM DD YYYY MM DD YYYY

Full disability from - - thru - - (date disability ends) or ongoing.
MM DD YYYY MM DD YYYY

Medical bills

Counsel fees to be paid by the employer.

Loss or loss of use of arm, hand, finger, leg, foot or toe.

Disfigurement (scars) of head, face or neck.

Loss of sight.

Loss of hearing.

Other _____

15. Is there other pending litigation in this case? Yes No If yes, explain below:

PLEASE ENTER MY APPEARANCE FOR PETITIONER:

Attorney's name _____

PA Attorney ID number _____

Firm name _____

Address _____

Address _____

City/Town _____ State _____ ZIP _____

Telephone _____

Date of petition
 - -
MM DD YYYY

Attorney's signature _____

Notice: This petition must be filled out as fully as possible. If not filing electronically, the original must be sent to the Workers' Compensation Office of Adjudication, 1010 N. Seventh St, Suite 202, Harrisburg, PA, 17102-1400. You must send a copy to all other parties, and on the attorneys of all other parties, if the attorneys are known. A Proof of Service must be attached. A Proof of Service is a signed statement signed by you verifying that you have sent a copy of the petition to all parties and their attorneys, if known. Questions regarding the completion of this form may be directed to the Bureau of Workers' Compensation Claims Information Services.

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*