



18. Other

Compensation benefits

- Have not been paid
- Being paid
- Have been paid based on a:

Notice of compensation payable dated  -  -

MM      DD      YYYY

Judge's order dated  -  -

MM      DD      YYYY

Agreement dated  -  -

MM      DD      YYYY

Board order dated  -  -

MM      DD      YYYY

Supplemental agreement dated  -  -

MM      DD      YYYY

Court order dated  -  -

MM      DD      YYYY

This is an Act 46 (firefighter cancer) claim

Is supersedeas being requested pursuant to Section 413(A.2)?  Yes  No  
If yes, list reasons:

Average weekly wage \$  .

Applicable weekly total disability rate \$  .

Date of most recent payment  -  -  Amount \$  .

MM      DD      YYYY

PLEASE ENTER MY APPEARANCE FOR PETITIONER:

Attorney's name \_\_\_\_\_

PA attorney ID number \_\_\_\_\_

Firm name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Telephone \_\_\_\_\_

COUNSEL FOR RESPONDENT (if known):

Attorney's name \_\_\_\_\_

PA attorney ID number \_\_\_\_\_

Firm name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Telephone \_\_\_\_\_

\_\_\_\_\_  
Petitioner or Representative's signature

Date of petition

-  -

MM      DD      YYYY

\_\_\_\_\_  
Petitioner or Representative's name (typed/printed)

**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 to 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 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*