

## NOTICE OF COMPENSATION PAYABLE

MH       DD		DATE OF NOTICE
Date of birh	EMPLOYEE	
Date of birth -   MM -   Date of birth -   MM -   County -   Telephone -   FEIN Nature of injury   Name -   Address -   County -   C		MM DD YYYY
Date of birth		DATE OF IN!' RY
Date of birth		
Date of birth		MM DD YY.
Imm DD     County     Telephone     Address     Address     City/Town     State     ZIP     County     IN., 'RY 'INFORMATION     Name     Address     City/Town     State     ZIP     County     IN., 'RY 'INFORMATION     Name     Address     Address     Address     County     Name   Address   County     Telephone   FEIN     Name   Address   County   County   Telephone   FEIN     Name   Address   County    County   County		SOCIA' SECUPTY NU BER
Imm DD     County     Telephone     Address     Address     City/Town     State     ZIP     County     IN., 'RY 'INFORMATION     Name     Address     City/Town     State     ZIP     County     IN., 'RY 'INFORMATION     Name     Address     Address     Address     County     Name   Address   County     Telephone   FEIN     Name   Address   County   County   Telephone   FEIN     Name   Address   County    County   County	Data of hirth	
Telephone   Name   Address   Address   City/Town   State   ZIP   County   Telephone   FEIN   Name   Address   Address   City/Town   State   ZIP   County   Telephone   FEIN   Name   Address   County   Telephone   FEIN   Name   Address   City/Town   State   ZIP   County   Check if occupational disease   Notice to EMPLOYER: This notice must be filed with the Bureau of Workers' Compensation via electronic format. A copy		W ID NUMBER
Telephone   Name   Address   Address   City/Town   State   ZIP   County   Telephone   FEIN   Name   Address   Address   City/Town   State   ZIP   County   Telephone   FEIN   Name   Address   County   Telephone   FEIN   Name   Address   City/Town   State   ZIP   County   Check if occupational disease   Notice to EMPLOYER: This notice must be filed with the Bureau of Workers' Compensation via electronic format. A copy	County	
EMPLOYER         Name         Address         Address         City/Town         State         City/Town         State         Telephone         FEIN         Name         Address         Cit /Town         State       ZIP         County         County         County		WCAIS CLAIM NUMBER
Address       INJ_RY_MFORMATION         Address       P2 t of body injured         Address       City/Town         County       FEIN         Insurer       Nature of injury         Name       Address         Address       Address         Address       Address         Address       Address         City/Town       State         State       ZIP         City/Town       State         FEIN       Accident/injury description narrative         City/Town       State         Telephone       FEIN         Insurer/Administrator clain #       County         TPA       County         County       County         Telephone       State         Cit/Town       State         County       County         County       County         County       Check if occupational disease         Check if occupational disease       NOTICE TO EMPLOYER: This notice must be filed with the Bureau of Workers' Compensation via electronic format. A copy	EMPLOYER	
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City/Town State ZIP   County		Pat of body injured
County   Telephone   FEIN     Name   Address   County   Telephone   FEIN   Name   Address   Address   County   State   ZIP   County   Check if occupational disease   NOTICE TO EMPLOYER: This notice must be filed with the Bureau of Workers' Compensation via electronic format. A copy		
Telephone       FEIN         INSURER       Nature of injury         Name		
INSURER   Name   Address   Address   Address   Address   County   County   Telephone   FEIN   NAIC code   Insurer/Administrator clain #		
INSURER         Name         Address         Address         Address         City/Town         State         City/Town         State         ZIP         County         Telephone         FEIN         NAIC code         Insurer/Administrator clein #         TPA         Name         Address         Address         Address         County         State         ZIP         County         County         County         County         County         County         County         Check if occupational disease         Check if occupational disease         NOTICE TO EMPLOYER: This notice must be filed with the Bureau of Workers' Compensation via electronic format. A copy	Telephone FEIN	Naturo of injuny
Address   Address   Address   City/Town   State   ZIP   County   Telephone   FEIN   Narce   Address   Address   Address   Cit / Town   State   ZIP   County   Check if occupational disease   Notice to employee:   Notice to employee:   Bureau of Workers' Compensation via electronic format. A copy	INSURER	
Address   City/Town   State   County   Telephone   FEIN   NAIC code   Insurer/Administrator clain #	Name	
City/Town State ZIP   County	Address	
City/Town State ZIP   County	Address	Accident/injury description narrative
County   Telephone   FEIN   NAIC code   Insurer/Administrator clain #     TPA   Name   Address   Address   Cit / Town   State   ZIP   Councy   Telephone   FEIN     NOTICE TO EMPLOYER: This notice must be filed with the Bureau of Workers' Compensation via electronic format. A copy	City/Town State 71P	
Telephone FEIN   NAIC code Insurer code   Insurer/Administrator clain #     TPA   Name   Address   Address   Cit / Town   State   ZIP   Councy   Telephone   FEIN     Notice to EMPLOYER: This notice must be filed with the Bureau of Workers' Compensation via electronic format. A copy		
NAIC code Insurer cride   Insurer/Administrator clain #   TPA   Name   Address   Address   Address   Citr/Town   Citr/Town   Councy   Telephone   FEIN        NAIC code		
Insurer/Administrator clain #		
TPA         Name         Address         Address         Address         Cit/Town         State         ZIP         Councy         Telephone         FEIN         NOTICE TO EMPLOYER: This notice must be filed with the Bureau of Workers' Compensation via electronic format. A copy		
Name		
Address	ТРА	
Address	Name	
Address	Address	
Councy	Address	County
Councy	Cit /Town State ZIP	Check if occupational disease
Telephone FEIN FEIN NOTICE TO EMPLOYER: This notice must be filed with the Bureau of Workers' Compensation via electronic format. A copy		
Bureau of Workers' Compensation via electronic format. A copy		
Insurer/Administrator claim #	Insurer/Administrator claim #	Bureau of Workers' Compensation via electronic format. A copy must be sent to the injured employee with the first payment of
compensation. A separate paper copy of this EDI-generated form should not be uploaded or sent to the Bureau.		compensation. A separate paper copy of this EDI-generated form

Specific information regarding this claim is on the reverse side of this form.

## A Statement of Wages, Form LIBC-494A or a Statement of Wages, Form LIBC-494C must be filed with every indemnity NCP or TNCP unless wages are estimated.

Compensation is payable as follows:

	Check only if compensation for medical treatment <b>(medical only, no loss of wages)</b> will be paid subject to the Workers' Compensation Act. Compensation for medical treatment is payable from the date of injury. For compensation for medical treatment only, you should not complete numbers 1 through 4.		
1. \	Neekly compensation rate \$		
	This box is checked if AWW is estimated. This box is checked if wages paid in lieu of compersion.		
2. F	Payments begin on MM DD YYYY (Compensation for loss of wages is payable for first seven days only disability extends 14 or more days; compensation for medical treatment payable from the date of injury.)		
	Section 308 of the PA Workers' Compensation Act generally provides that compensation shall be paid in privile installments as the wages of the employee were payable before the injury.		
/ j	Any termination, suspension, or modification of these payments must be made by agreen, nto manueceipt, administrative or udicial determination, or as otherwise provided in the Workers' Compensation Act or Degulations of the department.		
3. [	Date first check mailed This box is checked if dat_exceeds the 21-day Rule		
	If the injury involves a loss under Section 306(c) (except for disfigurement of the head, face, or neck) and the employee has returned to work, complete the following information:		
	(a) Compensation is payable for weeks days of loss or loss of use of		
	(b) Employee returned to work without loss of income or – –		
	(c) Healing period payable for weeks day. op to (b) above and subject to seven-day waiting period.)		
	(d) Total (a) and (c) payable weeks days		
	(e) Credit taken for disability benefit, paid 4		
Clai	ms representative's na ne Telephone		
NO.	TICE TO EMPLO FE: In y questions arise regarding these payments, contact the claims representative named above.		
	Any indices of filing usleading 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 InformationClaims Information ServicesHearing ImpairedServicestoll-free inside PA: 800.482.2383PA Relay 7-1-1		
	Services         toiline inside PA: 800.482.2363         PA Relay 7-1-1           717.772.3702         local & outside PA: 717.772.4447         PA Relay 7-1-1		
To view your claim file, log on to <u>www.wcais.pa.gov</u>			

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