

NOTICE STOPPING TEMPORARY COMPENSATION

EMPLOYEE

Date of birth - -
MM DD YYYY

County _____

Telephone _____

DATE OF NOTICE

- -
MM DD YYYY

DATE OF INJURY

- -
MM DD YYYY

SOCIAL SECURITY NUMBER

- -

W ID NUMBER

WCAIS CLAIM NUMBER

EMPLOYER

Name _____

Address _____

Address _____

City/Town _____ State _____ ZIP _____

County _____

Telephone _____ FEIN _____

INSURER

Name _____

Address _____

Address _____

City/Town _____ State _____ ZIP _____

County _____

Telephone _____ FEIN _____

NAIC code _____ Insurer code _____

Insurer/Administrator claim # _____

TPA

Name _____

Address _____

Address _____

City/Town _____ State _____ ZIP _____

County _____

Telephone _____ FEIN _____

Insurer/Administrator claim # _____

NOTICE TO INSURER: This notice must be filed in WCAIS via electronic format no later than five days after the last payment of temporary compensation. A copy must be sent to the employee. A separate paper copy of this EDI-generated form should not be uploaded or sent to the Bureau.

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

NOTICE TO EMPLOYEE: This notice is being sent because payment of compensation, being paid pursuant to the Notice of Temporary Compensation Payable, is being stopped as of - -

MM DD YYYY

The payment of temporary compensation does not mean that your employer assumed responsibility for your injury. Your employer and you retain all rights, defenses and obligations with regard to the claim. Further, the payment of temporary compensation may not be used to support a claim for benefits in a future proceeding.

WE HAVE DECIDED NOT TO ACCEPT LIABILITY AND ATTACHED IS A *NOTICE OF WORKERS' COMPENSATION DENIAL*. IF YOU BELIEVE YOU SUFFERED A WORK-RELATED INJURY, YOU WILL BE REQUIRED TO FILE A *CLAIM PETITION* WITH THE WORKERS' COMPENSATION OFFICE OF ADJUDICATION IN ORDER TO PROTECT YOUR FUTURE RIGHTS.

You have three years from the date of injury, or discovery of your condition, to file a Claim Petition for benefits. Since time limits can vary depending on the facts of your situation, you may wish to contact an attorney if you believe you may have a claim.

SAMPLE-NOT FOR USE

Claims representative name _____ 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
toll-free inside PA TTY: 800.362.4228
local & outside PA TTY: 717.772.4991

To view your claim file, log on to www.wcais.pa.gov

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