

CLAIM PETITION FOR BENEFITS FROM THE UNINSURED EMPLOYER AND THE UNINSURED EMPLOYERS GUARANTY FUND

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

□	□	□	-	□	□	-	□	□	□	□	□	□	□	□	□	□	□	□
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DATE OF INJURY

□	□	-	□	□	-	□	□	□	□	□	□
MM			DD			YYYY					

WCAIS CLAIM NUMBER

□	□	□	□	□	□	□	□	□	□	□	□
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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

AND

Pennsylvania Uninsured Employers Guaranty Fund 1171 S. Cameron St. Harrisburg, PA 17104

Employee should file this petition if they are seeking an award against their employer and the Uninsured Employers Guaranty Fund because their employer did not maintain workers' compensation insurance coverage and was not approved as a self-insurer at the time of the alleged injury. Note: You may not file this petition until 21 days after you filed a Notice of Claim Against Uninsured Employer, Form LIBC-551.

1. Have you filed a Notice of Claim Against the Uninsured Employer, Form LIBC-551? Yes No
2. Complete description of injury or illness including all parts of body affected. If fatality, provide cause of death.

3. If occupational disease, give the last date of employment

□	□	□	□
MM	DD	YYYY	

 and/or last date of exposure

□	□	□	□
MM	DD	YYYY	
4. Give date of injury or onset of disease

□	□	□	□
MM	DD	YYYY	
5. How did the injury or disease occur? _____
6. Did injury or disease occur on employer's premises? Yes No Where? (Be specific)

7. Notice of your injury or disease was served on your employer on

□	□	□	□
MM	DD	YYYY	

 in the following manner:

8. What was your job title at the time of injury or disease? _____
9. Were you working for more than one employer at the time of the injury? Yes No If yes, list additional employers:
10. Did this problem cause you to stop working? Yes No If yes, give date.

□	□	□	□
MM	DD	YYYY	
11. Are you back to work with the same employer? Yes No If yes, Regular job Other job/give title _____
12. Are you working with another employer? Yes No If yes, give name and address of new employer:

13. What were your weekly wages at the time of injury? \$.

14. Dependents are as follows:

NAME	ADDRESS	DATE OF BIRTH MM-DD-YYYY	RELATIONSHIP	US CITIZEN	
_____	_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

15. 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 weekly wages \$.

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

- Loss of Wages
 - Partial disability from - - to - -
 - Full disability from - - to - -
- Medical bills (give name of doctor/hospital, address, type of treatment and bill in space below.)
- Counsel fees to be paid by the employer. (Note: The Fund is not subject to unreasonable contest attorney fees.)
- Loss or loss of use of arm, hand, finger, leg, foot or toe.
- Disfigurement (scars) of head, face or neck.
- Injury or disease resulting in death. Date of death. - -
- Loss of sight
- Loss of hearing
- Cancer as a firefighter under Act 46 of 2011

17. Have you filed any other Workers' Compensation Petition(s) related to this injury/fatality? Yes No
If yes, PA BWC Claim Number (if known) _____.

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
 - -

A copy of this petition has been sent to the employer and the Fund.

Signature _____

Employee or Dependent Attorney

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 of this petition to the employer. 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
toll-free inside PA TTY: 800.362.4228
local & outside PA TTY: 717.772.4991

Email
ra-li-bwc-helpline@pa.gov



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