

EMPLOYEE VERIFICATION OF EMPLOYMENT, SELF-EMPLOYMENT OR CHANGE IN PHYSICAL CONDITION

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

EMPLOYER

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

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 # _____

INSTRUCTIONS TO EMPLOYEE:

DO NOT RETURN THIS FORM TO THE BUREAU OF WORKERS' COMPENSATION.

COMPLETED FORM MUST BE RETURNED TO THE PARTY WHO SENT THE FORM TO YOU WITHIN 30 DAYS OF YOUR RECEIPT OF THIS FORM.

IF YOU DO NOT COMPLETE AND RETURN THIS FORM TO THE PARTY WHO SENT IT TO YOU WITHIN 30 DAYS IT MAY RESULT IN A SUSPENSION OF YOUR COMPENSATION BENEFITS AS PROVIDED BY SECTION 311.1(g) OF THE WC ACT, AS WELL AS PROSECUTION FOR FRAUD UNDER ARTICLE XI OF THE WC ACT.

YOU MAY BE REQUIRED TO COMPLETE AND RETURN THIS FORM EVERY SIX MONTHS.

INSTRUCTIONS TO EMPLOYEE: Section 311.1(d) of the Workers' Compensation Act requires employees who are receiving workers' compensation, or have filed a petition to receive workers' compensation, to verify employment, self-employment, wages and changes to physical condition.

1. Are you currently employed by any employer other than the employer listed above? Yes No

2. Are you currently self-employed? Yes No

3. Have you been employed or self-employed at any time while receiving workers' compensation benefits? Yes No

4. Has your physical condition (caused by your injury) changed? Yes No

5. Is there other information you are aware of that is relevant in determining your entitlement to, or amount of compensation?
 Yes No

(OVER)

6. Names of employers for whom you have worked since your date of injury:

Name _____
 Address _____
 Address _____
 City/Town _____ State ____ ZIP _____
 Period of employment:
 From - -
 MM DD YYYY
 To - -
 MM DD YYYY
 Amount of wages \$ _____ . _____

Name _____
 Address _____
 Address _____
 City/Town _____ State ____ ZIP _____
 Period of employment:
 From - -
 MM DD YYYY
 To - -
 MM DD YYYY
 Amount of wages \$ _____ . _____

Name _____
 Address _____
 Address _____
 City/Town _____ State ____ ZIP _____
 Period of employment:
 From - -
 MM DD YYYY
 To - -
 MM DD YYYY
 Amount of wages \$ _____ . _____

IF SELF-EMPLOYED

From - -
 MM DD YYYY
 To - -
 MM DD YYYY
 Amount of wages \$ _____ . _____

I verify that this information is true and correct based upon my knowledge, information and belief. I understand false statements are subject to the penalties of 18 Pa. C.S. §4904 relating to unsworn falsification to authorities.

Employee

First name _____
 Last name _____
 Signature _____

DATE OF NOTICE
 - -
 MM DD YYYY

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*