pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

NOTICE OF SUSPENSION FOR FAILURE TO RETURN FORM LIBC-760

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

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

XXX - XX - ____ _____

DATE OF INJURY

__ - __ - ____
MM DD YYYY

WCAIS CLAIM NUMBER

_____

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 _____

DATE OF THIS NOTICE:

__ - __ - ____
MM DD YYYY

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 # _____

ATTORNEY FOR EMPLOYEE (if known)

Name _____

Firm name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

Telephone _____ PA Attorney ID number _____

ATTORNEY FOR INSURER/EMPLOYER (if known)

Name _____

Firm name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

Telephone _____ PA Attorney ID number _____

Name _____

Signature _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

Telephone _____ FEIN _____

A COPY OF THIS FORM AND ATTACHMENTS ARE TO BE PROVIDED TO THE EMPLOYEE AND THE EMPLOYEE'S ATTORNEY (IF KNOWN).

(OVER)

You are hereby notified that your workers' compensation benefits have been suspended as of ☐☐ - ☐☐ - ☐☐☐☐
MM DD YYYY

due to your failure to return the *Employee Verification of Employment, Self-Employment or Change in Physical Condition* form (LIBC-760) which was mailed to you on ☐☐ - ☐☐ - ☐☐☐☐
MM DD YYYY

This form was due for return to the sender within 30 calendar days of its receipt. Your failure to return the completed form within this time period entitles your insurer/employer to suspend your workers' compensation benefits under Section 311.1(g) of the Pennsylvania Workers' Compensation Act.

Your workers' compensation benefits will immediately begin again upon your insurer/employer's receipt of the verification form, but you will not receive reinstated benefits for the period of this suspension. In addition, failure to comply with the provisions of Section 311.1(d) may subject you to prosecution under the provisions of Article XI of the Pennsylvania Workers' Compensation Act relating to fraud.

If you did return the completed LIBC-760 within the prescribed time period, contact the forms sender (insurer/employer) immediately to clarify this matter.

Attached is another copy of the Employee Verification form to assure that you have the opportunity to complete and return it promptly to stop this suspension action.

You may challenge the suspension on legal grounds by filing a *Petition for Reinstatement* with the Pennsylvania Bureau of Workers' Compensation at the address listed on the front. Petitions can be obtained by calling the Bureau at 1-800-482-2383.

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