

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 DATE OF INJURY WCAIS CLAIM NUMBER MM DD YYYY EMPLOYEE First name Last name Address

| Date of birth | Address |
|---------------------|--|
| | City/Town State ZIP |
| Address | State 211 |
| Address | County |
| City/Town State ZIP | Telephone FEIN |
| County | INSURER or THIRD PARTY ADMINISTRATOR (if self-insured) |

| County | INSURER or THIRD PARTY ADMINISTRATOR (if self-insured) | | | | |
|-----------|--|------|--|--|--|
| Telephone | | Name | | | |

 DATE OF THIS NOTICE:
 City/Town _______ State ____ ZIP _______

 County _______
 County ________

Address _____

| ATTORNEY FOR EMPLOYEE (if known) | ATTORNEY FOR INSURER/EMPLOYER (if known) | | | | | | |
|----------------------------------|--|--|--|--|--|--|--|
| Name | Name | | | | | | |
| Firm name | Firm name | | | | | | |
| Address | Address | | | | | | |
| Address | Address | | | | | | |
| City/Town State ZIP | City/Town State ZIP | | | | | | |
| Telephone PA Attorney ID number | Telephone PA Attorney ID number | | | | | | |

| Name | |
|-----------|-----------|
| Signature | |
| Address | |
| Address | |
| City/Town | State ZIP |
| Telephone | FEIN |

| 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 Cha | nge in | Phys | sical C | onditio | n form (| LIBC-76 | 0) which | h was |
| mailed to you on DD - YYYYY | | | | | | | | |
| TI: () (| | | | | ٠. | | | |

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

