COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 S. CAMERON STREET, ROOM 103
HARRISBURG, PA 17104-2501
(TOLL FREE) 800-482-2383

NOTICE OF COMPENSATION PAYABLE

EMPLOYEE SOCIAL SECURITY NUMBER ___ - ___ - ___

DATE OF INJURY ___ - ___ - ___
MONTH DAY YEAR

PA BWC CLAIM NUMBER (IF KNOWN) ___

DATE OF NOTICE ___ - ___ - ___
MONTH DAY YEAR

EMPLOYEE

First Name ___
Last Name ___
Address ___
Address ___
City/Town ___ State ___ Zip ___
County ___
Telephone ( ) ___

EMPLOYER

Name ___
Address ___
Address ___
City/Town ___ State ___ Zip ___
County ___
Telephone ( ) ___ FEIN ___

INJURY INFORMATION

Body Part(s) affected ___
Type of Injury ___
Description of Injury ___
___
___
Check if Occupational Disease ☐

INSURER or THIRD PARTY ADMINISTRATOR (if self insured)

Name ___
Address ___
Address ___
City/Town ___ State ___ Zip ___
Telephone ( ) ___ Bureau Code ___
Claim # ___ FEIN ___

NOTICE TO EMPLOYER: This Notice should be clearly completed, (preferably typed) and mailed to the Bureau at the address in the upper left corner. A copy must be sent to the injured employee with the first payment of compensation.

NOTICE TO EMPLOYEE: If any questions arise regarding these payments, contact the representative named at the bottom of this Notice. If you cannot resolve a problem with the employer representative, you may call the Bureau at 800-482-2383.

Compensation is payable as follows:

☐ Check only if compensation for medical treatment **(medical only, no loss of wages)** will be paid subject to the Workers' Compensation Act. Compensation for medical treatment is payable from date of injury. For compensation for medical treatment only, you should not complete numbers 1 through 5.

1. Weekly compensation rate $ ___ . ___ Based on an average weekly wage of $ ___ . ___
2. Payments begin on ___ - ___ - ___ (MONTH DAY YEAR) (Compensation for loss of wages is payable for first 7 days only if disability extends 14 or more days; compensation for medical treatment is payable from the date of injury.)
3. Date first check mailed ___ - ___ - ___ (MONTH DAY YEAR) If the date exceeds the 21-Rule, check this box ☐ and explain on back of this form.
4. Payments will hereafter be made: ☐ Weekly ☐ Biweekly ☐ Other (Specify): ___
   Any termination, suspension or modification of these payments must be made by agreement, final receipt, administrative or judicial determination, or as otherwise provided in the Workers' Compensation Act or Regulations of the Department.
5. If injury involves loss under Section 306(c) (except for disfigurement of the head, face or neck) and employee has returned to work, complete the following information.
   (a) Compensation is payable for ___ weeks ___ days for loss or loss of use of ___.
   (b) Employee returned to work without loss of income on ___ - ___ - ___ (MONTH DAY YEAR)
   (c) Healing period payable for ___ weeks ___ days (Up to (b) above and subject to 7-day waiting period)
   (d) Total (a) and (c) payable ___ weeks ___ days.
   (e) Credit taken for disability benefits paid $ ___ . ___

495 0903

Name of Claims Representative ___ Phone Number ( )

___
Signature of Claims Representative

6. Remarks

Any individual filing misleading or incomplete information knowingly and with intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties through Pennsylvania Act 165.