

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

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

- -

DATE OF INJURY

- -

MM DD YYYY

WCAIS CLAIM NUMBER

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 or 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 - - and/or
last date of exposure - -
4. Give date of injury or onset of disease - -
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 - - in the following manner:

8. Did this problem cause you to stop working? Yes No If yes, give date. - -
9. What was your job title at the time of injury or disease? _____
10. Are you back to work with the same employer? Yes No If yes, Regular job Other job/give title _____
11. Are you working with another employer? Yes No If yes, give name and address of new employer:

12. What were your weekly wages at the time of injury? \$.
13. Were you working for more than one employer at the time of the injury? Yes No If yes, list additional employers:

14. If you have returned to work since your injury or illness, what are your weekly wages? \$.
15. Dependents/Guardians/Personal Representatives 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

16. I am seeking payment for (check all that apply):
- Loss of Wages
- Partial disability from - - to - - ongoing
- Full disability from - - to - - ongoing
- 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
- Other _____

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: A Claim Petition for Benefits from the Uninsured Employer and the Uninsured Employer's Guaranty Fund can be filed electronically by logging into WCAIS at www.WCAIS.pa.gov. If not filing electronically, a paper Claim Petition for Benefits from the Uninsured Employer and the Uninsured Employer's Guaranty Fund, Form LIBC-550, must be sent to the Workers' Compensation Office of Adjudication, 1010 N. Seventh St, Suite 202, Harrisburg PA 17102-1400. This petition must be filled out as fully as possible. You must send a copy of this petition to the employer. Questions may be directed to Workers' Compensation Office of Adjudication.

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).

<p>Workers' Compensation Office of Adjudication 844.237.6316 WCOAResourceCenter@pa.gov</p>	<p>Employer Information Services 717.772.3702</p>	<p>Claims Information Services toll-free inside PA TTY: 800.482.2383 local & outside PA TTY: 717.772.4447</p>	<p>Hearing Impaired PA Relay 7-1-1</p>
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*Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program*

