pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
KEYSTONE WORKS

WORKERS' COMPENSATION ACKNOWLEDGEMENT

I, _____ , acknowledge and understand that the Keystone Works Program requires me as the business entity to provide workers' compensation coverage to the Keystone Works Program claimant(s).

I understand that I must notify my workers' compensation insurer of my participation in the Keystone Works Program and must provide to the Department of Labor & Industry (L&I) the required proof of insurance coverage for Keystone Works Program claimants at my business.

I understand that any increase to my workers' compensation premiums for coverage of Keystone Works Program claimants during their participation at my business can be reimbursed by L&I, upon request and submission of required proof of such increase.

I understand that if self-insured, I am agreeing that the claimant will be covered under the business' self-insurance program.

I understand that I must timely report to my workers' compensation insurer, pursuant to all reporting requirements under the Pennsylvania Workers' Compensation Act, all work-related injuries to Keystone Works Program claimants during their participation in the program, and cooperate in my insurer's investigation and defense of any claim; in addition, I must notify L&I of such injuries within the same applicable reporting time periods.

X _____ _____
SIGNATURE OF BUSINESS REPRESENTATIVE DATE

_____ _____
NAME OF L&I REPRESENTATIVE DATE

X _____ _____
SIGNATURE OF L&I REPRESENTATIVE DATE

Please attach required proof of workers' compensation coverage.
If proof of coverage is not attached, your Keystone Works Training Application may be denied.

Submit

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program