pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

EMPLOYEE'S REPORT OF

(UNEMPLOYMENT COMPENSATION, SOCIAL SECURITY [OLD AGE], SEVERANCE AND PENSION BENEFITS)

BENEFITS FOR OFFSETS

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 ______
Address ______
Address ______
City/Town ______ State ____ ZIP ______
County ______
Telephone ______

EMPLOYER

Name ______
Address ______
Address ______
City/Town ______ State ____ ZIP ______
County ______
Telephone ______ FEIN ______

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 # ______

READ THE INSTRUCTIONS ON THE REVERSE SIDE BEFORE COMPLETING THIS FORM.

Section 204 of the Workers' Compensation Act requires employees receiving wage-loss benefits to report the receipt of unemployment compensation, social security (old age) benefits, severance and pension benefits.

COMPLETE AND RETURN THIS FORM TO THE INSURER OR SELF-INSURED EMPLOYER IDENTIFIED ON THIS FORM.

Complete the following information, indicating the type, amount and frequency (i.e.: weekly, biweekly, or other [specify]) of the benefits being received. Include the date such receipt began and ended (if applicable). If you are not receiving a particular type of benefit, indicate by writing "not applicable" or "none" in the appropriate space.

TYPE OF BENEFIT	AMOUNT RECEIVED	FREQUENCY	RECEIPT BEGAN DATE (MM/DD/YYYY)	RECEIPT ENDED DATE (MM/DD/YYYY)
Unemployment Compensation	Gross $ ______ . ____ Net $ ______ . ____	☐ Weekly ☐ Biweekly ☐ Other ______	____ / ____ / ______	____ / ____ / ______
Social Security (old age)	Gross $ ______ . ____ Net $ ______ . ____	☐ Weekly ☐ Biweekly ☐ Other ______	____ / ____ / ______	____ / ____ / ______
Severance	Gross $ ______ . ____ Net $ ______ . ____	☐ Weekly ☐ Biweekly ☐ Other ______	____ / ____ / ______	____ / ____ / ______
Pension	Gross $ ______ . ____ Net $ ______ . ____	☐ Weekly ☐ Biweekly ☐ Other ______	____ / ____ / ______	____ / ____ / ______

If you are receiving pension benefits from the employer directly liable for your workers' compensation, indicate the percent of the pension which is funded by the employer or check the box for 'percentage unknown'.

________% ☐ Percentage unknown

(OVER)

Did you "roll over" pension benefits into an IRA Account? ☐ Yes ☐ No Amount "rolled over" $ ___________ . _____
(IRA benefits are not offset until you begin withdrawing them from your account.)

I verify that this information is true and correct, based upon my knowledge, information and belief. I understand false statements are subject to the penalties of 18 Pa. C.S. §4909, relating to unsworn falsification to authorities.

____
Employee signature

DATE
☐☐ - ☐☐ - ☐☐☐☐
MM DD YYYY

If you are receiving any wages from employment or self-employment, check this box ☐. You must report this to your insurer or self-insured employer. Contact your insurer/employer for that reporting form (LIBC-760).

INSTRUCTIONS

TO EMPLOYEES:

If you are receiving workers' compensation wage-loss benefits due to an injury which occurred on or after June 24, 1996, you must report the receipt of the following:

- Unemployment compensation benefits
- Social Security (old age) benefits
- Severance benefits paid by the employer directly liable for your workers' compensation
- Pension benefits to the extent funded by the employer directly liable for your workers' compensation

Your workers' compensation benefits may be adjusted if you are receiving any of the above benefits. You are required to acknowledge both the receipt of and changes to any of the benefits listed above through the immediate completion and submission of this form.

FAILURE TO REPORT THE RECEIPT OF OR CHANGES TO ANY OF THE BENEFITS LISTED ABOVE MAY SUBJECT YOU TO PROSECUTION UNDER ARTICLE XI OF THE WORKERS' COMPENSATION ACT RELATING TO INSURANCE FRAUD.

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
toll-free inside PA TTY: 800.362.4228
local & outside PA TTY: 717.772.4991

Email
ra-li-bwc-helpline@pa.gov

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