pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

SUPPLEMENTAL AGREEMENT FOR COMPENSATION FOR DISABILITY OR PERMANENT INJURY

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 _____

Contact _____

NAIC code _____ or Insurer code _____

Insurer/TPA claim # _____

INJURY INFORMATION

Part of body injured _____

Nature of injury

Accident/injury description narrative

Check if occupational disease ☐

NOTICE: Agreement should be clearly completed, (preferably typed) and uploaded in accordance with the provisions of the EDI Implementation Guide. A copy must be sent to the employee. Weekly wages must be completed in accordance with the Pennsylvania Workers' Compensation Act.

Whereas, the undersigned employer and employee hereby agree that the status of the employee's disability changed on

__ - __ - ____ as follows:
MM DD YYYY

☐ Suspended, returned to work, no loss of wages
☐ Modification
☐ Specific loss

☐ Termination
☐ Recurred

Said employer shall pay employee compensation at the rate of $ _____ per week beginning on

__ - __ - ____
MM DD YYYY

Compensation is payable for _____ weeks _____ days; or, if the future period of disability is uncertain, then to continue at said-rate until further changed by supplemental agreement, final receipt, or order of a Workers' Compensation Judge, or the Workers' Compensation Appeal Board.

The employee's new partial compensation is based on the employee's present weekly earnings and is calculated as follows:

Calculation: _____ Average weekly wage at time of injury

Minus: _____ Present weekly earnings

_____ Subtotal

x 2/3= _____ New partial compensation rate (subject to the maximum benefit)

Further matters agreed upon (list any previously unreported periods of compensation and/or actions in chronological order, as well as additional information):

We, the undersigned, agree upon the matters represented herein by the above named employee and the above named employer.

_____
Employee's signature

Date of agreement
MM - DD - YYYY

_____
Claims Representative's signature

_____
Claims Representative's name (typed/printed)

Telephone _____

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