COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 S. CAMERON STREET, ROOM 103
HARRISBURG, PA 17104-2501
(TOLL FREE) 800.482.2383
TTY 800.362.4228

CLAIM PETITION FOR ADDITIONAL COMPENSATION FROM THE SUBSEQUENT INJURY FUND PURSUANT TO SECTION 306.1 OF THE WORKERS' COMPENSATION ACT

EMPLOYEE SOCIAL SECURITY NUMBER

DATE OF INJURY
MONTH DAY YEAR

PA BWC CLAIM NUMBER (IF KNOWN)

EMPLOYEE

First Name

Last Name

If Deceased - Dependent or Guardian

First Name

Last Name

Address

Address

City/Town State Zip

County

Telephone ( )

EMPLOYER

Name

Address

Address

City/Town State Zip

County

Telephone ( ) FEIN

VS. INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name

Address

Address

City/Town State Zip

Telephone ( ) Bureau Code

County

Claim # FEIN

And
Commonwealth of Pennsylvania, Department of Labor & Industry
Harrisburg, PA 17104-2501

An employee seeking additional compensation from the Subsequent Injury Fund should file this petition if the employee has previously incurred (through injury or otherwise) permanent partial disability, through the loss, or loss of use of, one hand, one arm, one foot, one leg or one eye, and incurs total disability through a subsequent injury, causing loss, or loss of use of, another hand, arm, foot, leg or eye.

1. Date of first (prior) loss or loss of use of, one hand, arm, foot, leg or eye, resulting in permanent partial disability.
   MONTH DAY YEAR

2. Complete description of first (prior) loss or loss of use.

   a. Was this loss or loss of use work-related? ☐ Yes ☐ No If Yes, name and address of employer:

3. Date of second (subsequent) loss, or loss of use of, another hand, arm, foot, leg or eye, resulting in total disability.
   MONTH DAY YEAR

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, 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).

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4. Complete description of second (subsequent) loss or loss of use injury.

   a. Was this loss or loss of use injury work-related? ☐ Yes ☐ No If Yes, name and address of employer:

5. Is there pending workers' compensation litigation or a previous Workers' Compensation Judge's decision regarding the second (subsequent) loss or loss of use injury? ☐ Yes ☐ No

   a. If Yes, when was the claim petition filed? MONTH ☐☐ – DAY ☐☐ – YEAR ☐☐☐☐

   b. If a Workers' Compensation Judge's decision was rendered, what was the circulation date of the decision?
   MONTH ☐☐ – DAY ☐☐ – YEAR ☐☐☐☐

   c. Was there an award of benefits for a specific loss or loss of use? ☐ Yes ☐ No

      i. If Yes, how many weeks of benefits were awarded? ☐☐☐

      ii. On what date did the specific loss award commence?
      MONTH ☐☐ – DAY ☐☐ – YEAR ☐☐☐☐

6. What were your wages at the time of the second (subsequent) injury? $ ☐☐☐☐ . ☐☐ ☐ Hour ☐ Day ☐ or Week

7. If you have returned to work since the second (subsequent) injury, are you earning than you were at the time of injury? Current earnings $ ☐☐☐☐ . ☐☐ ☐ More ☐ Same ☐ Less ☐ Hour ☐ Day ☐ or Week

   a. If Yes, what is your current average weekly wage? ☐☐☐☐ . ☐☐

8. Are you entitled to receive any other benefits by reason of your increased disability, either from any state or federal fund or agency? ☐ Yes ☐ No If Yes, please list.

PLEASE ENTER MY APPEARANCE FOR PETITIONER:

Attorney Name

PA Attorney ID Number

Firm Name

Address

Address

City/Town State Zip Code

Telephone ( )

Date of Petition
☐☐ – ☐☐ – ☐☐☐☐
MONTH DAY YEAR

A copy of this petition has been sent to the employer.

Signature
☐ Employee ☐ Attorney

NOTICE: This petition must be filled out as completely as possible. The original must be sent to the Bureau of Workers' Compensation, 1171 South Cameron Street, Room 103, Harrisburg, PA 17104-2501. A copy must be sent by you to the employer. Information on the completion of this form may be obtained by calling the Bureau of Workers' Compensation:

Employer Information Services	**Claims Information Services**	**Only People with Hearing Loss**	**E-mail**
717.772.3702	toll-free inside PA: 800.482.2383 local & outside PA: 717.772.4447	toll-free inside PA TTY: 800.362.4228 local & outside PA TTY: 717.772.4991	ra-li-bwc-helpline@ state.pa.us

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