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# RULES AND REGULATIONS

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## TITLE 34. LABOR AND INDUSTRY

### PART VIII. BUREAU OF WORKERS' COMPENSATION

#### CHAPTER 121. GENERAL PROVISIONS

##### § 121.1. Definitions

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Act -- The Workers' Compensation Act (77 P. S. §§ 1 -- 1041.4 and 2501 -- 2506).

Agreement -- For purposes of this chapter, an agreement is limited to any of the following:

- (i) Agreement for Compensation for Disability or Permanent Injury, Form LIBC-336.
- (ii) Supplemental Agreement for Compensation for Disability or Permanent Injury, Form LIBC-337.
- (iii) Agreement for Compensation for Death, Form LIBC-338.
- (iv) Supplemental Agreement for Compensation for Death, Form LIBC-339.

Approved rating organization -- One or more organizations situated within this Commonwealth, subject to supervision and to examination by the Insurance Commissioner and approved by the Insurance Commissioner as adequately equipped to perform the functions specified in Article VII of the act (77 P. S. §§ 1035.1 -- 1035.22) on an equitable and impartial basis.

Board -- The Workers' Compensation Appeal Board.

Bureau -- The Bureau of Workers' Compensation of the Department.

Claimant -- An individual who files a petition for, or otherwise receives, benefits under the act or the Disease Law.

Department -- The Department of Labor and Industry of the Commonwealth.

Disease Law -- The Occupational Disease Act (77 P. S. §§ 1201 -- 1603).

Earned premium -- A direct premium earned as required to be reported to the Insurance Department on Special Schedule "W," under section 655 of The Insurance Company Law of 1921 (40 P. S. § 815). For the purposes of this chapter, direct premium earned may not include:

- (i) The effects of premium credits granted under deductible elections by insured employer.
- (ii) Premiums not attributable to coverage under the act or the Disease Law.
- (iii) Premiums attributable to excess policies written for specified retentions on self-insured employers.

Employer -- As defined in section 401 of the act (77 P. S. § 701), including the insurer and a self-insured employer.

First report of injury -- A filing made with the Bureau under section 438 of the act (77 P.S. § 994).

Insurance carrier -- An entity or group of affiliated entities subject to The Insurance Company Law of 1921 (40 P. S. §§ 341 -- 477d), including the State Workers' Insurance Fund, but not including self-

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insured employers or runoff self-insurers, with which an employer has insured its liability under section 305 of the act (77 P. S. § 501).

**Insured employer** -- An employer which has chosen to insure its workers' compensation liabilities through a workers' compensation insurance carrier licensed to do so in this Commonwealth, including the State Workers' Insurance Fund.

**Insurer** --

- (i) A workers' compensation insurance carrier which is licensed to insure workers' compensation liabilities in this Commonwealth and acts in this capacity on behalf of insured employers.
- (ii) The term includes a self-insured employer and a runoff self-insurer.

**Runoff self-insurer** -- An employer that had been a self-insurer but no longer maintains a current permit to self-insure under section 305 of the act (77 P. S. § 501).

**Self-insured employer** --

- (i) An employer which has been granted the privilege to self-insure its liability under the act.
- (ii) The term includes a parent company or affiliate which has assumed a subsidiary's or an affiliate's liability upon the termination of the parent-subsidary or affiliate relationship, and a runoff self-insurer.

**Special funds** -- Funds maintained under sections 306.2, 443 and 446 of the act (77 P. S. §§ 517, 999 and 1000.2).

### § 121.2. [Reserved]

### § 121.3. Filing of forms

- (a) Forms must be in the format prescribed by the Bureau. All references to forms mean paper forms or an electronic format prescribed by the Bureau.
- (b) The Bureau may return forms that are not properly completed or filed. If a form is returned, the Bureau will notify the submitting party as to the reason the form was returned. For a form returned for the first time, the Bureau will preserve the filing date if the submitting party files a corrected version of the form within 14 days of the written notice of the return of the form.
- (c) The filing date is the date indicated on the United States Postal Service postmark or postal receipt. If the postmark or postal receipt is absent or unreadable, the filing date is the date of receipt by the Bureau. In all other instances, including electronic filing or hand-delivery, the filing date is the Bureau's date of receipt.

### § 121.3a. Computation of time

Except as otherwise provided by law, in computing a period of time prescribed or allowed by this chapter, the day of the act, event or default after which the designated period of time begins to run may not be included. The last day of the period so computed shall be included, unless it is Saturday, Sunday or a legal holiday in this Commonwealth, in which event the period shall run until the end of the next day which is neither a Saturday, Sunday nor a holiday. A part-day holiday shall be considered as other days and not as a holiday. Intermediate Saturdays, Sundays and holidays shall be included in the computation.

### § 121.3b. Providing workers' compensation information

- (a) The workers' compensation information specified in subsection (b) shall be provided to every employee at the time of hire and immediately after the injury, or as soon thereafter as possible under the circumstances of the injury. If the employee's injuries are so severe that emergency care is required, the information shall be given as soon after the occurrence of the injury as is practicable.

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- (b) The information shall be entitled “Workers’ Compensation Information” and include the following:
- (1) The workers’ compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.
  - (2) Benefits are required to be paid by your employer when self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers’ compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the treatment of injured employees or for the administration of first aid.
  - (3) You should report immediately any injury or work-related illness to your employer.
  - (4) Your benefits could be delayed or denied if you do not notify your employer immediately.
  - (5) If your claim is denied by your employer, you have the right to request a hearing before a workers’ compensation judge.
  - (6) The Bureau of Workers’ Compensation cannot provide legal advice. However, you may contact the Bureau of Workers’ Compensation for additional general information at: Bureau of Workers’ Compensation, 1171 South Cameron Street, Room 103, Harrisburg, Pennsylvania 17104-2501; telephone number within Pennsylvania (800) 482-2383; telephone number outside of this Commonwealth (717) 772-4447; TTY (800) 362-4228 (for hearing and speech impaired only); [www.state.pa.us](http://www.state.pa.us), PA Keyword: workers comp.
- (c) The information specified in subsection (b) must be printed on paper no smaller than 8 1/2 x 11 inches and in font no smaller than 11 point.

**§ 121.4. [Reserved]**

**§ 121.5. Reporting injuries to the Bureau**

- (a) The employer shall file a first report of injury as follows:
- (1) Within 48 hours for every injury resulting in death.
  - (2) Within 7 days after the date disability begins for all other injuries covered by section 438 of the act (77 P. S. § 994).
  - (3) If there is no disability, a copy of the report should not be sent to the Department.
- (b) The employer shall send a copy of the first report of injury to the employee simultaneously with filing it with the Bureau.
- (c) A disability that requires a first report of injury is defined as an injury only resulting in death or disability continuing the entire day, shift or turn, or longer, in which the injury was received.

**§ 121.6. [Reserved]**

**§ 121.7. Notice of compensation payable**

- (a) If an employer files a Notice of Compensation Payable, Form LIBC-495, the employer shall do all of the following simultaneously and no later than 21 days from the date the employer had notice or knowledge of the disability:
- (1) Send the Notice of Compensation Payable, Form LIBC-495, to the employee or the employee’s dependent.

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- (2) Pay compensation to the employee or to the employee's dependent.
  - (3) File the Notice of Compensation Payable, Form LIBC-495, with the Bureau.
- (b) A Statement of Wages, Form LIBC-494A, or Statement of Wages, Form LIBC-494C, shall be filed with every Notice of Compensation Payable, Form LIBC-495, except a Statement of Wages, Form LIBC-494A, or Statement of Wages, Form LIBC-494C, may not be filed with either of the following:
- (1) An estimated Notice of Compensation Payable, Form LIBC-495, filed under subsection (c).
  - (2) A Notice of Compensation Payable, Form LIBC-495, filed under subsection (e).
- (c) The employer may file a Notice of Compensation Payable, Form LIBC-495, based upon the employee's estimated wages if the employer has not obtained the wages necessary to properly calculate the employee's compensation payable. The estimated Notice of Compensation Payable, Form LIBC-495, shall be clearly identified as "Estimated."
- (d) If the estimated wages or compensation is not correct, the employer shall amend the estimated Notice of Compensation Payable, Form LIBC-495, upon receipt of the employee's actual wages in one of the following ways:
- (1) Amendments resulting in an increase in the employee's wage or compensation shall be filed with the Bureau under § 121.12 (relating to Bureau review of agreements and notices of compensation payable), and shall be clearly identified as "Amended" and may have only the insurer's signature.
  - (2) The employer shall file a Supplemental Agreement for Compensation for Disability or Permanent Injury, Form LIBC-337, under § 121.17 (relating to change in compensation) when there are changes resulting in a decrease in the employee's wage or compensation.
- (e) In medical only cases, when an employee's injury has not resulted in lost time from work, an employer may file a Notice of Compensation Payable, Form LIBC-495.

### **§ 121.7a. Notice of temporary compensation payable**

- (a) If an employer files a Notice of Temporary Compensation Payable, Form LIBC-501, the employer shall do all of the following simultaneously and no later than 21 days from the date the employer had notice or knowledge of the disability:
- (1) Send the Notice of Temporary Compensation Payable, Form LIBC-501, to the employee or the employee's dependent.
  - (2) Pay compensation to the employee or to the employee's dependent.
  - (3) File the Notice of Temporary Compensation Payable, Form LIBC-501, with the Bureau.
- (b) A Statement of Wages, Form LIBC-494A or Statement of Wages, Form LIBC-494C, shall be filed with every Notice of Temporary Compensation Payable, Form LIBC-501, except a Statement of Wages, Form LIBC-494A or Statement of Wages, Form LIBC-494C, may not be filed with a Notice of Temporary Compensation Payable, Form LIBC-501, filed under subsection (d).
- (c) To modify a Notice of Temporary Compensation Payable, Form LIBC-501, an employer shall file an amended Notice of Temporary Compensation Payable, Form LIBC-501, with the Bureau during the 90-day temporary compensation payable period. The amended Notice of Temporary Compensation Payable, Form LIBC-501, shall be clearly identified as "Amended" and may have only the insurer's signature.

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- (1) A Statement of Wages, Form LIBC-494A, or Statement of Wages, Form LIBC-494C, shall be filed with every amended Notice of Temporary Compensation Payable, Form LIBC-501.
  - (2) This section does not apply upon conversion of the Notice of Temporary Compensation Payable, Form LIBC-501, to a Notice of Compensation Payable, Form LIBC-495.
- (d) In medical only cases, when an employee's injury has not resulted in lost time from work, an employer may file a Notice of Temporary Compensation Payable, Form LIBC-501.

### **§ 121.8. Agreements for compensation for disability or permanent injury**

- (a) An Agreement for Compensation for Disability or Permanent Injury, Form LIBC-336, shall be completed before being signed by the employer and the employee. If the employer and the employee enter into an agreement, the employer shall do all of the following simultaneously and not later than 21 days from the date the employer had notice or knowledge of the disability:
- (1) Send the fully-executed agreement to the employee.
  - (2) Pay compensation to the employee.
  - (3) File the agreement with the Bureau.
- (b) A Statement of Wages, Form LIBC-494A, or Statement of Wages, Form LIBC-494C, shall be filed with every Agreement for Compensation for Disability or Permanent Injury, Form LIBC-336.
- (c) If the employer has not obtained the wages necessary to properly calculate the employee's compensation payable, an Agreement for Compensation for Disability or Permanent Injury, Form LIBC-336, based upon the employee's estimated wages may be filed. The estimated Agreement for Compensation for Disability or Permanent Injury, Form LIBC-336, shall be clearly identified as "Estimated."
- (d) If the estimated wages or compensation is not correct, the employer shall amend the estimated Agreement for Compensation for Disability or Permanent Injury, Form LIBC-336, upon receipt of the employee's actual wages.
- (1) Amendments resulting in an increase in the employee's wage or compensation shall be filed with the Bureau under § 121.12 (relating to Bureau review of agreements and notices of compensation payable), and shall be clearly identified as "Amended."
  - (2) The employer shall file a Supplemental Agreement for Compensation for Disability or Permanent Injury, Form LIBC-337, under § 121.17 (relating to change in compensation) when there are changes resulting in a decrease in the employee's wage or compensation.

### **§ 121.9. Agreements for compensation for death**

- (a) If a compensable injury results in death, an Agreement for Compensation for Death, Form LIBC-338, shall be executed between an employer and the deceased's dependents or personal representative and filed with the Bureau. An Agreement for Compensation for Death, Form LIBC-338, shall be completed before being signed by an employer and a deceased's dependents or personal representative.
- (b) A Statement of Wages, Form LIBC-494A, or Statement of Wages, Form LIBC-494C, shall be filed with every Agreement for Compensation for Death, Form LIBC-338.
- (c) If death results from the injury, compensation payments to the dependents for the death benefit shall begin from the date of the employee's death.

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(d) If the employer has not obtained the wages necessary to properly calculate the employee's compensation payable, an Agreement for Compensation for Death, Form LIBC-338, based on the employee's estimated wages may be filed. The estimated Agreement for Compensation for Death, Form LIBC-338, shall be clearly identified as "Estimated."

(e) If the estimated wages or compensation is not correct, the employer shall amend the estimated Agreement for Compensation for Death, Form LIBC-338, upon receipt of the employee's actual wages.

(1) Amendments resulting in an increase in the employee's wage or dependent's compensation shall be filed with the Bureau under § 121.12 (relating to Bureau review of agreements and notices of compensation payable), and shall be clearly identified as "Amended."

(2) The employer shall file a Supplemental Agreement for Compensation for Disability or Permanent Injury, Form LIBC-337, under § 121.17 (relating to change in compensation) when there are changes resulting in a decrease in the employee's wage or compensation.

### § 121.10. [Reserved]

### § 121.11. Supplemental agreements for compensation for death

(a) A Supplemental Agreement for Compensation for Death, Form LIBC-339, may be used to change an Agreement for Compensation for Death, Form LIBC-338, or an award. A Supplemental Agreement for Compensation for Death, Form LIBC-339, shall be completed before being signed by an employer and a deceased's dependents or personal representative.

(b) An Agreement for Compensation for Death, Form LIBC-338, shall be changed for any of the following reasons:

(1) Birth of a posthumous child.

(2) A change in dependent's status, including death.

(3) A surviving spouse dies, remarries or becomes capable of self-support and any dependent children remain eligible for benefits.

(c) The Bureau will presume that the surviving parent is guardian for purposes of receiving compensation under the act.

(d) The completed Supplemental Agreement for Compensation for Death, Form LIBC-339, shall be sent to all of the deceased's dependents or their personal representative and filed with the Bureau.

### § 121.12. Bureau review of agreements and notices of compensation payable

(a) Errors in computing wages shall be corrected by filing an amended version of the agreement or Notice of Compensation Payable, Form LIBC-495, with the Bureau if correction of errors would increase the employee's wage or compensation.

(1) The amended agreement or Notice of Compensation Payable, Form LIBC-495, shall be clearly identified as "Amended."

(2) A Statement of Wages, Form LIBC-494A, or Statement of Wages, Form LIBC-494C, shall be filed with every amended agreement or Notice of Compensation Payable, Form LIBC-495.

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(b) The employer shall file a Supplemental Agreement for Compensation for Disability or Permanent Injury, Form LIBC-337, under § 121.17 (relating to change in compensation) when there are changes resulting in a decrease in the employee's wage or compensation.

### § 121.13. Denial of compensation

If compensation is controverted, a Notice of Workers' Compensation Denial, Form LIBC-496, shall be sent to the employee or dependent and filed with the Bureau, fully stating the grounds upon which the right to compensation is controverted, within 21 days after notice or knowledge to the employer of the employee's disability or death.

### § 121.14. Weekly wage for occupational disease cases

For cases involving occupational diseases under the act, the weekly wage will be determined in accordance with section 309 of the act (77 P. S. § 582), and a claimant's compensation rate shall be subject to the maximum compensation payable rate in effect at the date of last exposure.

### § 121.15. Compensation payable

(a) In computing the time when the disability becomes compensable, the day the injured employee is unable to continue at work by reason of the injury shall be counted as the first day of disability in the 7 day waiting period. If the injured employee is paid full wages for the day, shift or turn on which the injury occurred, the following day shall be counted as the first day of disability. In determining the waiting period or time during which compensation is payable, each calendar day, including Sundays and holidays, shall be counted. In determining the period of disability, seven should be used as a divisor to determine the number, and any part, of the weeks.

(b) If death results from the injury, compensation payments to the dependents for death benefits shall begin from the date of the employee's death.

(c) If death results more than 7 days after the injury, compensation payments covering the disability period should be paid as set forth in this chapter, and compensation payments because of death due to the injury shall start from the date of death.

(d) Compensation due to the date of death shall be paid to the nearest of kin, or in the absence of same, to the estate.

### § 121.16. Updating claims status

(a) The following paragraphs apply to the Annual Claims Status Report, Form LIBC-774:

(1) The Bureau will provide the Annual Claims Status Report, Form LIBC-774, to an insurer each year before March 1.

(2) The insurer shall file a completed Annual Claims Status Report, Form LIBC-774, including any attachment required to support the data reported, to the Bureau each year before June 1.

(3) If an insurance carrier fails to file the completed report, the Bureau may recommend that the Insurance Commissioner revoke or suspend the insurance carrier's license under section 441(a) of the act (77 P. S. § 997(a)).

(4) If a self-insured employer fails to timely file the completed report, the Secretary of the Department may revoke or suspend the self-insured employer's privilege to carry its own risk under section 441(b) of the act.

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(5) The Annual Claims Status Report must contain a list of all open claims which were initiated by the filing of a Bureau document other than a first report of injury, more than 3 calendar years before the calendar year in which the report is filed and on which no activity was reported to the Bureau during the calendar year immediately before the report year.

(6) Only open claims which were initiated with the Bureau during calendar year 2004 and thereafter may be listed in the Annual Claims Status Report.

(b) A Final Statement of Account of Compensation Paid, Form LIBC-392A, shall be filed with the Bureau immediately after the final payment of compensation.

### **§ 121.17. Change in compensation**

(a) If an injured employee has recovered from an injury, or a deceased employee's dependent or personal representative is no longer eligible to receive death benefits, an Agreement to Stop Weekly Workers' Compensation Payments (Final Receipt), Form LIBC-340, may be executed by the parties. The executed agreement shall be filed with the Bureau.

(b) Termination, suspension, modification or other change in compensation may be accomplished by filing with the Bureau a Supplemental Agreement for Compensation for Disability or Permanent Injury, Form LIBC-337. A Supplemental Agreement for Compensation for Disability or Permanent Injury, Form LIBC-337, may be used to change an Agreement for Compensation for Disability or Permanent Injury, Form LIBC-336, a Supplemental Agreement for Compensation for Disability or Permanent Injury, Form LIBC-337, an Agreement for Compensation for Death, Form LIBC-338, a Notice of Compensation Payable, Form LIBC-495, or an award. A Supplemental Agreement for Compensation for Disability or Permanent Injury, Form LIBC-337, shall be completed before being signed by the employer and the employee. The completed Supplemental Agreement for Compensation for Disability or Permanent Injury, Form LIBC-337, shall be sent to the employee or his dependents and filed with the Bureau.

(c) A suspension or modification of compensation may be accomplished by the employer mailing a Notification of Suspension or Modification Pursuant to §§ 413 (c) and (d), Form LIBC-751, to the Bureau and the employee. The wage calculation on the Notification of Suspension or Modification Pursuant to §§ 413 (c) and (d), Form LIBC-751, shall be completed for a modification.

(d) If temporary payments made under § 121.7a (relating to notice of temporary compensation payable) are stopped, the employer shall file one of the following:

(1) A Notice Stopping Temporary Compensation, Form LIBC-502, and a Notice of Workers' Compensation Denial, Form LIBC-496, within 5 days of the last payment and within the 90-day temporary compensation payable period.

(2) A Notice of Compensation Payable, Form LIBC-495.

(3) An Agreement for Compensation for Disability or Permanent Injury, Form LIBC-336.

(e) The employer may not file a Notification of Suspension or Modification Pursuant to §§ 413 (c) and (d), Form LIBC-751, to stop temporary payments made under § 121.7a.

(f) If termination, suspension or modification of compensation cannot be achieved through subsection (a), (b), (c) or (d), the employer may file a Petition To: Terminate (stop payment of worker's compensation), Terminate (based upon physician's affidavit, a special supersedeas hearing to be scheduled), Modify or Suspend Compensation Benefits, Form LIBC-378.

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### § 121.18. Subrogation

(a) If an employee obtains a third-party recovery under section 319 of the act (77 P. S. § 671), a Third Party Settlement Agreement, Form LIBC-380, shall be executed by the parties.

(b) If credit is requested against future compensation payable, a Supplemental Agreement for Compensation for Disability or Permanent Injury, Form LIBC-337, may also be filed with the Bureau, including the amount and periodic method of pro rata reimbursement of attorney fees and expenses.

### § 121.19. [Reserved]

### § 121.20. Commutation of compensation under section 412 of the act (77 P. S. § 791)

Commutation under section 412 of the act (77 P. S. § 791) shall only be allowed for the final 52-week period or less. The commutation amount may not be paid in installments. A Commutation of Compensation, Form LIBC-498, shall be filed with the Bureau.

### § 121.21. Reimbursement for silicosis, anthraco-silicosis or coal workers' pneumoconiosis

(a) Claims for compensation for silicosis, anthraco-silicosis or coal workers' pneumoconiosis as defined in section 108(q) of the act (77 P. S. § 27.1(q)), for disability or death, when the date of disability commences or death occurs between July 1, 1973, and June 30, 1976, inclusive, and when the liable employer is seeking to offset part of its liability under section 305.1 of the act (77 P. S. § 411.1), shall be instituted by filing a Claim Petition for Workers' Compensation, Form LIBC-362, with the Bureau.

(b) Unless stayed by a supersedeas on appeal, following the issuance of an award by the workers' compensation judge, the Board or the appellate court, compensation payments for silicosis, anthracosilicosis or coal workers' pneumoconiosis shall be made in full by the insurer. If the insurer seeks reimbursement from the Bureau under section 305.1 of the act, it shall submit the following to the Bureau:

(1) A notarized statement, signed by an officer of the company, containing an itemized list of payments made to all claimants for quarterly reimbursement. Each itemized entry must contain the claimant's name, address, Social Security number and the total amount paid to the claimant. Each itemized list shall be made for a full and exact calendar quarter: that is, January 1 through March 31; April 1 through June 30; July 1 through September 30; or October 1 through December 31. Each list must have two categories: recurring quarterly reimbursement and initial payment made to each claimant, which payment should include the current reimbursable quarter. Each list submitted must be in roster form and in numerical order according to the claimant's Social Security number, contain the claimant's name and Social Security number, cover the amount to be reimbursed and the total amount paid to the claimant, and be reported to the Bureau.

(2) Each bill containing the itemized entries shall be submitted to the Bureau no later than the 15th day of the month following the end of the calendar quarter for which reimbursement is sought. A bill received after that date will not be considered for payment until the end of the following quarter.

(c) For auditing purposes, an insurer shall keep records for 3 years from the date of each payment made under this section. The records shall be made available for inspection by the Bureau during normal business hours.

(d) If the Bureau believes that the insurer primarily liable for compensation under the act has failed to make a payment under the act and this section, the Bureau may pay compensation directly to the claimant, for the portion of the compensation which is payable by the Commonwealth under section 305.1 of the act until the insurer resumes payment of compensation. The Bureau is not required to initiate direct payments to a claimant when the insurer is making full payment of the compensation but is not seeking reimbursement under this section.

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**§ 121.22. Subsequent injury fund**

(a) Compensation for a subsequent injury, as defined in section 306.1 of the act (77 P. S. § 516) shall be paid as follows:

(1) The employer is responsible for payments due for specific loss under section 306(c) of the act (77 P. S. § 513).

(2) Upon expiration of the specific loss period, the Bureau will be responsible for additional compensation due for the duration of total disability. The fund established under section 306.2 of the act (77 P. S. § 517), from which these payments are to be made, shall be maintained as follows:

(i) Self-insured employers shall pay assessments in amounts determined by the following:

Amount of Compensation Paid by a Self-insured Employer during the Preceding Calendar Year.	X	The Amount Expended From the Subsequent Injury Fund During the Preceding Calendar Year
Total Amount of Compensation Paid by All Insurers During the Preceding Calendar year		

(ii) The amount expended from the Subsequent Injury Fund during the preceding calendar year, minus the total amount owed by all self-insured employers, as calculated under subparagraph (i), shall equal the aggregate amount to be collected by insurance carriers.

(b) Insurance carriers shall remit to the Bureau assessment amounts as follows:

Amount of Premium as Reported to the Insurance Department, by Insurance Carrier for the Preceding Calendar Year	X	Aggregate Amount to be collected by Insurance Carriers
Total Amount of Earned Premium Reported to the Insurance Department, By all Insurance Carriers For the Preceding Calendar		

(c) If the amount of earned premium as reported to the Insurance Department, by an insurance carrier, for the preceding calendar year is less than zero, the Bureau will calculate the assessment amount as though an earned premium amount of zero were reported to the Insurance Department.

(d) Insured employers shall remit assessment amounts through their insurance carriers, according to procedures defined by the approved rating organization and approved by the Insurance Commissioner.

(e) Self-insured employers and runoff self-insurers shall pay assessments directly to the Bureau.

(f) The claimant shall file a Claim Petition for Additional Compensation from the Subsequent Injury Fund Pursuant to Section 306.1 of the Workers' Compensation Act, Form LIBC-375, as provided in section 315 of the act (77 P. S. § 602) or the claim will be forever barred.

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**§ 121.23. Supersedeas fund**

(a) Annual assessments under section 443 of the act (77 P. S. § 999) shall be in amounts determined by the following:

(1) Self-insured employers shall pay assessments in amounts determined by the following:

Amount of Compensation Paid By a Self-insured Employer During the Preceding Calendar Year	X	The Amount of Supersedeas Payments Made or Accrued as Payable During the Preceding Calendar Year
<hr style="border: 0.5px solid black;"/> Total Amount of Compensation Paid By All Insurers During the Preceding Calendar Year		

(2) The amount of supersedeas payments made or accrued as payable during the preceding year, minus the total amount owed by all self-insured employers, as calculated under paragraph (1), shall equal the aggregate amount to be collected by insurance carriers.

(3) Insurance carriers shall remit to the Bureau assessment amounts as follows:

Amount of Earned Premium As Reported to the Insurance Department, by an Insurance Carrier For the Preceding Calendar Year	X	Aggregate Amount to be Collected By Insurance Carriers
<hr style="border: 0.5px solid black;"/> Total Amount of Earned Premium Reported to the Insurance Department by all Insurance Carriers for the Preceding Calendar Year		

(b) If the amount of earned premium as reported to the Insurance Department, by an insurance carrier, for the preceding calendar year is less than zero, the Bureau will calculate the assessment amount as though an earned premium amount of zero were reported to the Insurance Department.

(c) Insured employers shall remit assessment amounts through their insurance carriers, according to procedures defined by the approved rating organization and approved by the Insurance Commissioner.

(d) Self-insured employers and runoff self-insurers shall pay assessments directly to the Bureau.

(e) Applications for reimbursement shall be filed directly with the Bureau on an Application for Supersedeas Fund Reimbursement, Form LIBC-662. Applications will be processed administratively to determine whether the parties can agree on the payment or amount of reimbursement. If the payment or amount of reimbursement cannot be agreed upon, the matter will be assigned to a workers' compensation judge for a formal hearing and adjudication.

**§ 121.24. [Reserved]**

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### § 121.25. Issuance of compensation payments

Compensation payments shall be issued according to the following:

- (1) Unless the claimant and the employer have executed an Authorization for Alternative Delivery of Compensation Payments, Form LIBC-10, or unless payment is otherwise ordered by a workers' compensation judge, the Board or any court, a claimant's payment for workers' compensation or occupational disease compensation shall be mailed by first-class mail to the claimant's last known address, and may not be made payable to, or delivered to, an attorney unless the attorney is the administrator or executor of the claimant's estate, a court-appointed trustee, a court-appointed guardian or acting in some other fiduciary capacity.
- (2) Notice of the first payment to a claimant shall be sent to counsel of record by the insurer or self-insured employer.
- (3) If a workers' compensation judge or the Board approves attorneys' fees and costs, a payment for fees and costs, separate from a compensation payment, shall be made payable, and issued, to the claimant's attorney.
- (4) An employer may not require a claimant to appear at a specific place to receive compensation payments.

### § 121.26. [Reserved]

### § 121.27. Orders to show cause

- (a) The Department may serve an order to show cause on a respondent for an alleged violation of the act or regulations contained in this part. The order to show cause will contain the particulars of the alleged violation and the procedures for filing an answer under subsection (b).
- (b) A written answer to the order to show cause may be filed no later than 20 days after the date that the order to show cause is served on the respondent. The answer must admit or deny the allegations in the order to show cause and state respondent's defense. General denials that are unsupported by specific facts will not comply with this section and may be deemed a basis for entry of a final order because the respondent has raised no issues requiring further proceedings. The facts in the order to show cause may be deemed admitted if a respondent fails to file a timely answer under this subsection.
- (c) The Director of Adjudication will assign the order to show cause to a presiding officer who will schedule a hearing. The presiding officer will provide notice to the parties of the hearing date, time and place.
- (d) The hearing will be conducted under this section and 1 Pa. Code Part II (relating to General Rules of Administrative Practice and Procedure) to the extent not specifically superseded in subsection (h). The presiding officer will not be bound by strict rules of evidence.
- (e) Hearings will be stenographically recorded and the transcript of the proceedings will be part of the record.
- (f) If the respondent fails to appear in person or by counsel at the scheduled hearing without adequate excuse, the presiding officer will decide the matter on the basis of the order to show cause and evidence presented.
- (g) The Department has the burden to demonstrate, upon a preponderance of the evidence, that the respondent failed to comply with the act or regulations in this part.
- (h) This section supersedes 1 Pa. Code §§ 35.14, 35.37, 35.131, 35.201 and 35.221.

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### § 121.27a. Bureau intervention and penalties

- (a) If the workers' compensation judge determines that penalties resulting from an alleged violation of the act or regulations in this part may be imposed on a party under section 435 of the act (77 P. S. § 991), the workers' compensation judge may notify the Bureau in writing within 20 days of the notice of the alleged violation.
- (b) The workers' compensation judge will include a description of the nature of the alleged violation in the notice and will provide the Bureau with an opportunity to participate in the proceeding as an intervening party. The workers' compensation judge simultaneously will provide a copy of the notification to all parties.
- (c) Within 20 days after receipt of the notice, the Bureau will notify the workers' compensation judge and the parties of its decision to participate in the proceeding or to allow the proceeding to continue without intervention. If the Bureau fails to respond to the notification within 20 days, the Bureau will not have intervened. By not intervening before the workers' compensation judge, the Bureau has not waived its right to intervene in a different forum or following additional notice from the workers' compensation judge in the same proceeding.
- (d) Nothing in this section may be construed to require the Bureau to intervene in any matter or to restrain a workers' compensation judge from notifying the Bureau of a further alleged violation of the act or regulations in a case.
- (e) This section supplements §§ 131.121 and 131.122 (relating to penalty proceedings initiated by a party; and other penalty proceedings).

### § 121.28. [Reserved]

### § 121.29. [Reserved]

### § 121.30. Section 306(h) payments (77 P. S. § 583)

- (a) Under section 306(h) of the act (77 P. S. § 583), insurers shall submit a listing of all pre-August 31, 1993, cases on which compensation is still payable under sections 306(a), 306(23) or 307 of the act (77 P. S. §§ 511, 513(23), 561, 562 and 542), in an amount less than \$100 per week on January 1, 2007. This listing must contain the following particulars:
- (1) Bureau code.
  - (2) Name of claimant.
  - (3) Social Security number.
  - (4) Claimant's date of birth.
  - (5) Date of injury.
  - (6) Name of employer.
  - (7) Insurer claim number.
  - (8) Current weekly compensation rate.
- (b) If the insurer seeks reimbursement from the Bureau under section 306(h) of the act, it shall submit the following to the Bureau on a quarterly basis: a notarized statement, signed by an officer of the company, containing an itemized list of payments made to all claimants, submitted no later than the 10th day of the month following the quarter for which advance reimbursement payments have been made. Each itemized entry must contain the following information: the claimant's name, Social Security number and the total amount paid each claimant per quarter.
- (c) Changes in a payment schedule to an individual shall be reported to the Bureau within 10 days of the change. The Bureau will take credit in the following reimbursable quarter for an overpayment caused by change in a payment schedule.

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(d) For auditing purposes, every insurer shall keep records for 3 years from the date of each payment made under this section. The records will be made available for inspection by the Bureau during normal business hours.

(e) If the Bureau believes that the insurer primarily liable for compensation under the act has failed to make a payment under the act and this section, the Bureau may pay compensation directly to the claimant, for the portion of the compensation which is payable by the Commonwealth under section 306(h) of the act until the insurer resumes payment of compensation. The Bureau is not required to initiate direct payments to a claimant when the insurer is making full payment of the compensation but is not seeking reimbursement under this section.

**§ 121.31. Workmen’s Compensation Administration Fund**

(a) Annual assessments on self-insured employers, under section 446(b) of the act (77 P. S. § 1000.2(b)), shall be in amounts determined by the following:

Amount of Compensation Paid by a Self-insured Employer during the Preceding Calendar year	X	The Approved Budget of the Workmen’s Compensation Administration Fund For the Current Fiscal Year
Total Amount of Compensation Paid by All Insurers during the Preceding Calendar Year		

(b) The approved budget of the Workmen’s Compensation Administration Fund for the current fiscal year, minus the total amount owed by all self-insured employers, as calculated under subsection (a), shall equal the aggregate amount to be collected by insurance carriers.

(c) Insurance carriers shall remit to the Bureau assessment amounts as follows:

Amount of Earned Premium as Reported to the Insurance Department, by an Insurance Carrier For the Preceding Calendar Year	X	Aggregate Amount To be Collected By Insurance Carriers
Total Amount of Earned Premium Reported to the Insurance Department By all Insurance Carriers For the Preceding Calendar Year		

(d) If the amount of earned premium as reported to the Insurance Department, by an insurance carrier, for the preceding calendar year is less than zero, the Bureau will calculate the assessment amount as though an earned premium amount of zero were reported to the Insurance Department.

(e) Insured employers shall remit assessment amounts through their insurance carriers, according to procedures defined by the approved rating organization and approved by the Insurance Commissioner.

(f) Self-insured employers and runoff self-insurers shall pay assessments directly to the Bureau.

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**§ 121.32. Office of Small Business Advocate**

(a) The Bureau may collect annual assessments imposed on insurance carriers, but not on self-insured employers or runoff self-insurers, for the purpose of funding the Office of Small Business Advocate in accordance with section 1303 of the act (77 P. S. § 1041.3). Insurance carriers shall be directly liable to the Bureau for prompt payment of assessments for the Office of Small Business Advocate, as provided in the act and this chapter.

(b) Annual assessments under section 1303 of the act shall be in amounts as determined by the following formula:

Amount of Compensation Paid by an Insurance Carrier, but not a Self-insured Employer or Runoff Self-insurer, During the Preceding Calendar Year	X	The Approved Budget of the Office of Small Business Advocate for the Current Fiscal Year
Total Amount of Compensation Paid by All Insurance Carriers, but not Self-insured Employers or Runoff Self-insurers, During the Preceding Calendar Year		

**§ 121.33. Collection of special funds assessments**

(a) The Bureau will collect assessments for the special funds by calculating the total amount of the following:

- (1) What each self-insured employer is liable for paying to the Bureau.
- (2) What each insurance carrier is responsible for collecting from insured employers and remitting to the Bureau.

(b) Assessments for the special funds will be imposed, collected and remitted as follows:

- (1) The Bureau will transmit to each insurance carrier and self-insured employer a notice of assessment amount to be collected, which will specify the amount calculated under subsection (a) and the date on which the amount is due.
- (2) Each self-insured employer shall timely remit to the Bureau the amount calculated under subsection (a)(1).
- (3) Each insurance carrier shall collect payment for assessments from insured employers according to the procedures defined by the approved rating organization and approved by the Insurance Commissioner and timely remit payment to the Bureau.
- (4) The failure of an insurance carrier to receive payment from an insured employer does not limit an insurance carrier's responsibility to collect and timely remit to the Bureau the total amount calculated under subsection (a)(2).

**§ 121.34. Objections to assessments**

(a) A party receiving a notice of assessment amount to be collected from the Bureau may, within 15 days of receipt, object to the assessment reflected in the notice on the basis that it is excessive, erroneous, unlawful or invalid. Insured employers retain all rights provided under section 717 of the act (77 P. S. § 1035.17).

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(b) Objections must be set forth in numbered paragraphs, specifically state the facts necessary to determine the validity of the challenged assessment or assessment amount and be accompanied by a supporting memorandum documenting the legal grounds for the objections.

(c) An objection to assessment or assessment amount shall be accompanied by a proof of service as specified in 1 Pa. Code § 33.35 (relating to proof of service) and a notice of appearance as specified in 1 Pa. Code § 31.24 (relating to notice of appearance), and be served on all interested parties as specified in 1 Pa. Code § 33.32 (relating to service by a participant).

(d) An objection not conforming to this section or the act will be rejected by the Bureau. The Bureau will notify the objecting party of the specific reasons for the rejection. The objecting party shall have 30 days to cure any deficiency.

(e) Upon receipt of an objection which conforms to this section and the act, the Department will hold a hearing in accordance with 1 Pa. Code Part II (relating to General Rules of Administrative Practice and Procedure). After the hearing, the Department will record its findings on any objections and will transmit to the objector, by registered or certified mail, notice of the amount, if any, charged against it in accordance with the findings. The amount shall be paid by the objector within 10 days after receipt of the findings. After payment has been made, the objector may initiate an action in the appropriate court to recover the payment of the assessment or any portion thereof. An insurer may not maintain an action to recover payment unless it has previously objected under subsection (a).

### **§ 121.35. Annual reports of compensation paid**

Every annual report of compensation paid made by an insurer under sections 445 and 446(e) of the act (77 P. S. §§ 1000.1 and 1000.2(e)) must include amounts paid by an insurer for which policyholders have agreed to reimburse the insurer under deductible policies issued under section 448 of the act (77 P. S. § 1000.4).