COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 S. CAMERON STREET, ROOM 103
HARRISBURG, PA 17104-2501
(TOLL FREE) 800-482-2383
TTY 800-362-4228

AUTHORIZATION FOR ALTERNATIVE DELIVERY OF COMPENSATION PAYMENTS

Social Security Number: _____ - _____ - _____

Date of Injury _____ /_____ /_____
MM DD YYYY

PA BWC Claim Number: _____
(IF KNOWN)

Employee

Name

Street 1

Street 2

City/Town State Zip Code

County Telephone
(_____) _____-_____

Employer

Name

Street 1

Street 2

City/Town State Zip Code

County

Telephone FEIN
(_____) _____-_____

Insurer or Third Party Administrator (if self-insured)

Name

Street 1

Street 2

City/Town State Zip Code

Telephone Bureau Code
(_____) _____-_____

County

Claim Number FEIN

DATE OF AUTHORIZATION

_____ /_____ /_____
MM DD YYYY

I, _____, hereby authorize and agree that the checks for the compensation
CLAIMANT NAME (PLEASE PRINT)
payments due to me shall be forwarded to me in the following designated manner:

☐ I will pick up my checks at (please check only one box): ☐ employer office ☐ insurer office

☐ The employer/insurer will mail my checks to me at:

_____

_____

☐ The employer/insurer will direct deposit my checks to the account at the financial institution supplied on the attached authorization for direct deposit. (Attach authorization for direct deposit provided by your financial institution.)

☐ Other:

_____

_____

_____

I understand that my employer/insurer is required to mail my compensation checks to my last known address and that I am not under any obligation to authorize the method of delivery outlined above.

_____
CLAIMANT'S NAME

_____
NAME OF EMPLOYER/INSURER REPRESENTATIVE

_____
CLAIMANT'S SIGNATURE

_____
SIGNATURE OF EMPLOYER/INSURER REPRESENTATIVE