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

DEFENDANT'S ANSWER TO CLAIM PETITION UNDER PENNSYLVANIA WORKERS' COMPENSATION ACT

Social Security Number: _____ - _____ - _____

Date of Injury _____ /_____ /_____
MM DD YYYY

PA BWC Claim Number: _____
(IF KNOWN)

Employee

First Name _____ Last 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 _____

VS.

Insurer, Fund or Third Party Administrator (if self-insured)

Name _____

Street 1 _____

Street 2 _____

City/Town _____ State _____ Zip Code _____-_____

Telephone (_____) _____-_____ Bureau Code _____

County _____

Claim Number _____ FEIN _____

"FUND" SHALL MEAN THE UNINSURED EMPLOYERS GUARANTY FUND, SUBSEQUENT INJURY FUND, SELF-INSURANCE GUARANTY FUND OR PRE-SELF-INSURANCE GUARANTY FUND.

TO YOUR HONORABLE JUDGE:

In answer to the captioned claim, the Defendant respectfully pleads as follows: (Answers must be identified by numerical order in direct response to corresponding numbered allegations on claim petition.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

NOTICE: This answer should be clearly completed (preferably typed) and original mailed directly to the office of the Judge to whom the case is assigned. Answers must be filed within 20 days. Every fact alleged in the claim petition not specifically denied by this answer shall be deemed to be admitted.

374 0811

As a matter of further defense, the Defendant states the following:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

WHEREFORE, the Defendant requests that the claim petition be dismissed or in the alternative disallowed.

Defendant

First Name _____ Last Name _____

Signature _____

Date: _____/_____/_____
MM DD YYYY

Attorney

Signature _____

Date: _____/_____/_____
MM DD YYYY

PLEASE ENTER MY APPEARANCE FOR DEFENDANT:
Attorney

First Name _____ Last Name _____

Firm Name _____

Street 1 _____

Street 2 _____

City/Town _____ State _____ Zip Code _____-_____

Telephone (_____) _____-_____ PA Attorney ID Number _____

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).

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