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

OCCUPATIONAL DISEASE CLAIM PETITION

MONTHLY COMPENSATION FOR DISABILITY UNDER SECTION 301(i) ONLY

Social Security Number: _____ - _____ - _____

PA BWC Claim Number: _____
(IF KNOWN)

Employee

First Name _____ Last Name _____

Street 1 _____

Street 2 _____

City/Town _____ State _____ Zip Code _____-_____

County _____ Telephone (_____) _____ - _____

vs.

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

1. My last date of employment or self-employment in any occupation was _____/_____/_____ .
   MM DD YYYY

2. I became totally disabled on _____/_____/_____ as a result of:
   MM DD YYYY

   ☐ Coal Worker's Pneumoconiosis ☐ Silicosis ☐ Anthraco-Silicosis ☐ Asbestosis

3. My total disability is a result of employment in a hazardous occupation having a
   ☐ Coal hazard ☐ Asbestos hazard ☐ Silica hazard.

4. I was employed in the Commonwealth of Pennsylvania at least two years preceding the above date of disability, as follows: (List all employment in the hazardous occupation.)

NAME OF EMPLOYER IN PENNSYLVANIA	ADDRESS	DATES OF EMPLOYMENT FROM (MM/DD/YYYY)	TO (MM/DD/YYYY)
		____/____/_____	____/____/_____
		____/____/_____	____/____/_____
		____/____/_____	____/____/_____
		____/____/_____	____/____/_____
		____/____/_____	____/____/_____
		____/____/_____	____/____/_____

5. If you have filed a claim previously under the Occupational Disease Act or the Workers' Compensation Act, complete the following:

   (a) Date of filing: ____/____/_____
   MM DD YYYY

   (b) Claim Petition: ☐ Pending ☐ Dismissed ☐ Withdrawn

   (c) Claim Filed Under: ☐ Occupational Disease Act ☐ Workers' Compensation Act

6. I ☐ have ☐ have not filed for benefits under the Federal Health and Coal Mine Safety Act of 1969.

396 1009

Therefore, I hereby petition the Department of Labor & Industry to award monthly compensation to me at the rate set forth under the provisions of Section 301(i) of the 1939 Occupational Disease Act, as amended.

DATE OF THIS NOTICE: _____/_____/_____
MM DD YYYY

Petitioner

First Name	Last Name
_____	_____
_____	
	Signature

PLEASE ENTER MY APPEARANCE FOR PETITIONER:

Attorney

Name
_____
Firm Name
_____
Street 1
_____
Street 2
_____
City/Town _____ State _____ Zip Code _____-_____
Telephone (_____) _____-_____ PA Attorney ID Number _____

INSTRUCTIONS TO CLAIMANT

Failure to comply with these instructions will necessitate the return of your petition.

Employee must **sign this document**.

Attach two recent photographs. Place your signature and Social Security Number on the reverse side of each photograph.

NOTICE: Petition should be clearly completed (preferably typed) and original mailed to the Bureau at the address in the upper left corner of Page 1.

If you have questions or need information on the completion of this form, please contact 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

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).

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