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

FINAL STATEMENT OF ACCOUNT OF COMPENSATION PAID

EMPLOYEE SOCIAL SECURITY NUMBER

DATE OF INJURY

MONTH DAY YEAR

PA BWC CLAIM NUMBER (IF KNOWN)

EMPLOYEE

First Name
Last Name
Address
Address
City/Town State Zip
County
Telephone ( )

EMPLOYER

Name
Address
Address
City/Town State Zip
County
Telephone ( ) FEIN

INSURER or THIRD PARTY ADMINISTRATOR (if self insured)

Name
Address
Address
City/Town State Zip
Telephone ( ) Bureau Code
County
Claim # FEIN

NOTICE: A Final Statement of Account shall be filed after the final payment of compensation.

This is to certify that the above named employer or insurer has paid compensation under the Pennsylvania Workers' Compensation Act in the above case as follows:

Rate	From Date	To Date	#Wks	#Days	Total
_____.__	__-__-__	__-__-__	___	___	_____.__
_____.__	__-__-__	__-__-__	___	___	_____.__
_____.__	__-__-__	__-__-__	___	___	_____.__

*Additional payment periods or remarks should be indicated on the reverse side of this form.

Medical Payments $ ___ ___ ___ ___ ___ ___ ___ ___ . ___ ___

Indemnity Payments $ ___ ___ ___ ___ ___ ___ ___ ___ . ___ ___

Other Payments $ ___ ___ ___ ___ ___ ___ ___ ___ . ___ ___

TOTAL COMPENSATION PAID **$** ___ ___ ___ ___ ___ ___ ___ ___ . ___ ___

392A 0908

Remarks/Additional Information:

Name of Employer/Insurer Representative

DATE

Signature of Employer/Insurer Representative

Month Day Year

392A 0908

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