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

NOTICE OF COMPENSATION PAYABLE

EMPLOYEE SOCIAL SECURITY NUMBER ___ - __ - ____

DATE OF INJURY __ - __ - ____ (MONTH DAY YEAR)

DATE OF NOTICE __ - __ - ____ (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
Claim # FEIN

INJURY INFORMATION

Body Part(s) affected
Type of Injury
Description of Injury

Check if Occupational Disease ☐

NOTICE TO EMPLOYER: This Notice should be clearly completed, (preferably typed) and mailed to the Bureau at the address in the upper left corner. A copy must be sent to the injured employee with the first payment of compensation.
NOTICE TO EMPLOYEE: If any questions arise regarding these payments, contact the representative named at the bottom of this Notice. If you cannot resolve a problem with the employer representative, you may call the Bureau at 800-482-2383.

Compensation is payable as follows:

☐ Check only if compensation for medical treatment **(medical only, no loss of wages)** will be paid subject to the Workers' Compensation Act. Compensation for medical treatment is payable from date of injury. For compensation for medical treatment only, you should not complete numbers 1 through 5.

1. Weekly compensation rate $ ____ . __ Based on an average weekly wage of $ ____ . __
2. Payments begin on __ - __ - ____ (MONTH DAY YEAR) (Compensation for loss of wages is payable for first 7 days only if disability extends 14 or more days; compensation for medical treatment is payable from the date of injury.)
3. Date first check mailed __ - __ - ____ (MONTH DAY YEAR) If the date exceeds the 21-Rule, check this box ☐ and explain on back of this form.
4. Payments will hereafter be made: ☐ Weekly ☐ Biweekly ☐ Other (Specify): _____
   Any termination, suspension or modification of these payments must be made by agreement, final receipt, administrative or judicial determination, or as otherwise provided in the Workers' Compensation Act or Regulations of the Department.
5. If injury involves loss under Section 306(c) (except for disfigurement of the head, face or neck) and employee has returned to work, complete the following information.
   (a) Compensation is payable for ____ weeks ____ days for loss or loss of use of _____.
   (b) Employee returned to work without loss of income on __ - __ - ____ (MONTH DAY YEAR)
   (c) Healing period payable for ____ weeks ____ days (Up to (b) above and subject to 7-day waiting period)
   (d) Total (a) and (c) payable ____ weeks ____ days.
   (e) Credit taken for disability benefits paid $ ____ . __

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Name of Claims Representative _____ Phone Number ( )

Signature of Claims Representative

LIBC-495 REV 9-03

(OVER)

6. Remarks

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 and may also be subject to criminal and civil penalties through Pennsylvania Act 165.