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

NOTICE OF CLAIM AGAINST UNINSURED EMPLOYER

EMPLOYEE SOCIAL SECURITY NUMBER ___ - __ - ____

DATE OF INJURY __ - __ - ____
MONTH **DAY** **YEAR**

Instructions: Please complete both sides of this form and mail to the address listed above. You must also forward a copy to the Pennsylvania Uninsured Employers Guaranty Fund at P.O. Box 1774, Harrisburg, PA 17105-1774. **You must complete all questions that appear in bold print or the bureau will not accept this form and will return it to you.** A Claim Petition for Benefits From the Uninsured Employer and the Uninsured Employers Guaranty Fund, Form LIBC-550, may not be filed until 21 days after filing this form.

EMPLOYEE	**EMPLOYER**
Name	**Name**
Address	**Address**
City/Town **State** **Zip**	**City/Town** **State** **Zip**
County	County
Telephone ( )	Telephone ( )
Date of Birth	**Owner/Contact**

INJURY

Did the injury result in a fatality? ☐ Yes ☐ No

Where did the injury occur: Street Address: _____ **City:** _____ **State:** ____

Describe the incident and injury.

Was the injury reported to the employer? ☐ Yes ☐ No **If Yes, when?** _____ **To whom?** _____

DISABILITY

Occupation/Job Title _____

List the employee's weekly wages at the time of injury _____

Last day worked _____ **Hours worked per week** _____

ATTACH MOST RECENT PAY STATEMENT OR CHECK/STUB.

Did the injury cause a loss of wages? ☐ Yes ☐ No

Has the employer been paying for lost wages? ☐ Yes ☐ No

Has the employee returned to work? ☐ Yes ☐ No **If so, when?** _____

How much is the employee earning? $ _____ per hour / day / week (circle one)

For whom does the employee work? Give name, address and telephone number. _____

MEDICAL

Has the employee sought medical treatment for the work injury? ☐ Yes ☐ No

Has the employer paid for medical treatment for the work injury? ☐ Yes ☐ No

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List Doctors/Medical Facilities and their addresses. (Attach additional sheets, if necessary.)

The injured employee (or dependent, if the employee is deceased) must complete and sign the following authorization, which the Uninsured Employers Guaranty Fund may use to collect records relating to medical treatment that the injured or deceased employee received, and to collect wage information from the injured or deceased employee's current or previous employer(s).

AUTHORIZATION TO RELEASE INFORMATION / VERIFICATION OF INFORMATION

To Whom It May Concern:

By signing below, I hereby request and authorize you to furnish, to the Pennsylvania Uninsured Employers Guaranty Fund or its representative(s), any and all information you have concerning the above-named employee with respect to any illness or injury, medical history, consultation, treatment, including x-rays, as well as copies of all hospital or medical records, military records or other government records.

I further request and authorize employers to furnish complete information concerning wages, commissions and the like. By signing below, I attest that I am the employee identified above, or that I am the deceased employee's dependent authorized to request the release of such records, and that I am pursuing a claim for benefits under the Pennsylvania Workers' Compensation Act.

A photocopy of this authorization shall be considered as effective and valid as the original authorization.

VERIFICATION

By signing below, I verify that all information submitted on this form is, to the best of my knowledge, information and belief, true, complete and correct. I understand that any individual who knowingly and with the intent to defraud, files misleading or incomplete information, is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to civil and criminal penalties, including prosecutions under 18 Pa. C.S.A. §4903 (relating to false swearing).

Employee or Dependent Signature: _____

Print Name: _____

Address: _____

_____

_____

Phone: _____ **Dated:** _____

Relationship to deceased employee, if applicable: _____

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