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
TTY 800-362-4228

APPLICATION FOR SUPERSEDEAS FUND REIMBURSEMENT

Social Security Number: ____ - ___ - _____

Date of Injury: _____/_____/_____
MM DD YYYY

PA BWC Claim Number: _____
(IF KNOWN)

This application is filed on behalf of: ☐ **Insurer** ☐ **Self-Insured Employer**

Employee

First Name _____ Last Name _____

SEE INSTRUCTIONS ON REVERSE

662 0707

Employer

Name _____
Street 1 _____
Street 2 _____
City/Town _____ State _____ Zip Code _____-_____
County _____ FEIN _____
Telephone (_____)_____-_____

Insurer or Third Party Administrator (if self-insured)

Name _____
Street 1 _____
Street 2 _____
City/Town _____ State _____ Zip Code _____-_____
County _____ FEIN _____
Telephone (_____)_____-_____
Claim Number _____

TO THE DEPARTMENT OF LABOR AND INDUSTRY, BUREAU OF WORKERS' COMPENSATION:

As insurer/self-insurer in the above case, we herewith request reimbursement of compensation paid to claimant pursuant to Section 443 of the Pennsylvania Workers' Compensation Act.

IN SUPPORT OF THE ABOVE REQUEST, WE OFFER THE FOLLOWING FACTS:

Request for supersedeas was filed on _____/_____/_____ (MM DD YYYY) in connection with ☐ petition or ☐ appeal filed on _____/_____/_____ (MM DD YYYY) for ☐ termination ☐ modification ☐ suspension of compensation as of _____/_____/_____. (MM DD YYYY)

Insurer's/self-insurer's request for supersedeas was
☐ granted on _____/_____/_____ (MM DD YYYY)
☐ denied on _____/_____/_____ (MM DD YYYY)
☐ not acted on (and therefore deemed denied)

as a result of which insurer/self-insurer continued payment of compensation from _____/_____/_____ (MM DD YYYY) until the final outcome of the proceedings on _____/_____/_____ (MM DD YYYY), at which time it was determined that such compensation was not, in fact, payable.

Is there a potential or existing third-party action? ☐ Yes ☐ No If yes, list docket number _____(if known).

Insurer/self-insurer verifies that the underlying case is not on appeal, that the appeal period has expired, and there is no other litigation pending which would affect Supersedeas Fund Reimbursement. Insurer/self-insurer affirmatively states that the decision issued by

_____ dated _____/_____/_____ (MM DD YYYY) is final.

(OVER)

INSURER/SELF-INSURER, THEREFORE, REQUESTS REIMBURSEMENT OF ITS OVERPAYMENT OF COMPENSATION AS FOLLOWS:

Compensation attributable to, and subsequently paid for, _____ weeks and _____ days from _____/_____/_____ (MM DD YYYY)

to _____/_____/_____ (MM DD YYYY) inclusive at $_____.____ per week for TOTAL OF $ _____.____. During the above

time period, medical expenses were incurred, and subsequently paid, for a TOTAL OF $_____.____. Proof

of payment of the above averments are attached hereto. The following unusual payment circumstances, if any,

are:_____

_____

Other matters alleged: _____

_____

_____

_____

VERIFICATION

I UNDERSTAND THAT FALSE STATEMENTS HEREIN ARE MADE SUBJECT TO THE PENALTIES OF 18 PA. C.S. §4904 RELATING TO UNSWORN FALSIFICATION TO AUTHORITIES.

Submitter

Name and Title

_____

Phone Number

_____

Signature

_____

Attorney for/Representative of

_____

INSTRUCTIONS

All requests for reimbursement from the Supersedeas Fund pursuant to Article IV, Section 443, of the Pennsylvania Workers' Compensation Act (Act) must be by application on Form LIBC-662, *Application for Supersedeas Fund Reimbursement.* The Application must be fully completed, including all dates requested. Applicants must verify that the parties have not filed an appeal, and that the decision is final.

Any information that supports the Application, including underlying petitions and decisions, must be attached to the Application. Any information relating to a potential or existing third-party recovery (including but not limited to the third party settlement agreement), compromise and release agreement, or other matter which may affect this application, must also be attached. The claimant's social security number, BWC Claim Number (if known) and name must be included on each attached page.

Applicant also must file proof of payment, which must be attached to the Application. Proof of payment should be in the form of copies of canceled checks or computer printouts of payment records. Also, proof of payment must include dates of service for indemnity and medical expenses incurred and payee names.

Failure to fully complete the Application or to attach the required supporting documentation and proof of payment will result in the Application being returned without processing.

An Application may be assigned to a Workers' Compensation Judge for a hearing and determination of eligibility for reimbursement pursuant to the Act.

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 of 1994.

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