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

NOTIFICATION OF SUSPENSION OR MODIFICATION PURSUANT TO § § 413 (C) & (D)

EMPLOYEE SOCIAL SECURITY NUMBER ___ - __ - ____

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

PA BWC CLAIM NUMBER (IF KNOWN)

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

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

INSTRUCTIONS:

A copy of this form must be served by the employer/insurer upon employee with the original form mailed to the Bureau. This form must be mailed to the employee within seven days of a suspension or modification of benefits under this provision of the Workers' Compensation Act.

Both sides must be completed.

You are hereby notified that because you returned to work on __ - __ - ____ (MONTH DAY YEAR), your weekly disability benefits for this injury have been:

☐ Suspended effective __ - __ - ____ (MONTH DAY YEAR) because you have returned to work at earnings equal to or greater than your time-of-injury earnings of $ _____.

OR

☐ Modified to the rate of $ ____ . __ per week, effective __ - __ - ____ (MONTH DAY YEAR) because you returned to work at earnings less than your time-of-injury earnings.

INSURER'S AFFIDAVIT

I attest or affirm that the statements contained herein are true and correct to the best of my knowledge, information and belief.

_____
Signature of Employer/Insurer Representative

affix seal here

NOTE TO EMPLOYEE:
If you do not agree with this action and wish to challenge it, please read the instructions under EMPLOYEE CHALLENGE on the back of this form.

SUBSCRIBED AND SWORN TO (OR AFFIRMED) BEFORE ME THIS

_____ DAY OF _____, _____

_____
Signature of Notary

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.

751 0506

CALCULATION for partial compensation rate (to be completed for Modification):

Calculation:	____ . __	Average Weekly Wage at Time of Injury
minus:	____ . __	Present Weekly Earnings
	____ . __	Subtotal
x 2/3=	____ . __	New Partial Compensation Rate (Subject to the maximum benefit)

EMPLOYEE CHALLENGE:

If you do not agree with this action, you should challenge it by checking the box below, signing this form and mailing it to the Pennsylvania Department of Labor & Industry, Bureau of Workers' Compensation, 1171 South Cameron Street, Room 103, Harrisburg, PA 17104. This material must be filed with the Bureau within twenty (20) days from the date you received it.

If you do not challenge this action within twenty (20) days of the date you receive this Notice, you will be deemed to have admitted that you agree with the action taken on this form. In that case, this Notice will have the same binding effect as a fully executed Supplemental Agreement for the suspension or modification of benefits.

☐ I do not agree with the action taken by my employer. I request a special supersedeas hearing (a hearing on whether my workers' compensation benefits can be reduced or stopped) before a Workers' Compensation Judge. A hearing is requested to be conducted in accordance with Sections 413 (c) & (d) of the Pennsylvania Workers' Compensation Act.

(If the employee has legal counsel, complete below.)

Attorney Name _____

PA Attorney ID# _____

Name of Firm _____

Address _____

Address _____

City/Town _____ State _____ Zip _____

Telephone ( ) _____

Employee Signature _____

Address _____

Address _____

City/Town _____ State _____ Zip _____

County _____

Telephone ( ) _____

(Employee to complete if different from information provided by employer)

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