pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

APPLICATION FOR BENEFITS UNDER SECTION 909 OF THE WORKERS' COMPENSATION ACT

1. Claimant information
   First name: _____
   Last name: _____
   Address: _____
   _____
   City: _____ State: _____ Zip: _____

2. Social Security number: _____

3. Date of injury: _____

4. Date of birth: _____

5. PA BWC claim number, if known: _____

6. Name and address of defaulted self-insured employer:
   Name: _____
   Address: _____
   _____
   City: _____ State: _____ Zip: _____

7. Date of filing of the Agreement for Compensation, Notice of Compensation Payable, or Petition for Compensation initiating your compensation benefits (if known):
   _____

8. When did you last receive workers' compensation benefits (if known)?
   _____

9. Who was the company, or insurer, that paid the last workers' compensation benefits (if known)?
   _____

10. Are you now employed? Yes ☐ No ☐
    If yes, provide the following:
    Name of Employer: _____
    Address: _____
    _____
    City: _____ State: _____ Zip: _____

    Date employment started _____
    Amount of wages $_____ per week ☐ month ☐ annual ☐

11. Are you now self-employed? Yes ☐ No ☐

If yes, provide the following:
Date employment started _____
Amount of wages $_____ per week ☐ month ☐ annual ☐

12. If you are receiving any of the following benefits, complete the following information, indicating the type, amount, and frequency (i.e., weekly, bi-weekly, or other [specify]) of the benefits being received. Include the date such receipt began.

If you are not receiving a particular type of benefits, indicate by writing "Not Applicable" or "None" in the space.

Type of Benefit	Amount Received	Frequency	Receipt Began Date
Unemployment compensation	Gross $_____ Net $_____	_____ Weekly _____ Bi-weekly _____ Other _____	_____ / _____ / _____ _____ / _____ / _____ _____ / _____ / _____
Social Security (old age)	Gross $_____ Net $_____	_____ Weekly _____ Bi-weekly _____ Other _____	_____ / _____ / _____ _____ / _____ / _____ _____ / _____ / _____
Pension	Gross $_____ Net $_____	_____ Weekly _____ Bi-weekly _____ Other _____	_____ / _____ / _____ _____ / _____ / _____ _____ / _____ / _____

13. Are you receiving pension benefits from the defaulted self-insured employer directly liable for your workers' compensation? Yes ☐ No ☐

Did you "rollover" pension benefits into an IRA account: Yes ☐ No ☐

Amount rolled over? $_____

14. Are you receiving medical treatment or prescription drugs which are covered or paid by, in whole or part, insurance other than workers' compensation or by a federal, state or private benefit program; such as Medicare, Medicaid or a retirement benefit program?

Yes ☐ No ☐

If yes, provide the name, address and phone number of the insurer or program.

_____

_____

_____

_____

15. Has your physical condition (caused by your work injury) changed since you last received workers' compensation benefits? Yes ☐ No ☐

If yes, please explain:

_____

_____

_____

_____

16. Is there any other information you are aware of that is relevant in determining your qualification for benefits or amount of benefits under Section 909 of the Workers' Compensation Act? Yes ☐ No ☐

If yes, please explain:

_____

_____

_____

_____

I hereby apply for benefits from the prefund account of the Self-Insured Guaranty Fund. I verify that this information is true and correct based upon my knowledge, information, and belief. I understand false statements are subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsifications to authorities. 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.

Claimant:

_____
Print full name

_____
Sign full name

_____
Date of application

Send the completed Application for Benefits Under Section 909 of the Workers' Compensation Act to:

Pennsylvania Bureau of Workers' Compensation
Self-Insurance Division
651 Boas Street, 8th Floor
Harrisburg, PA 17121-0750
717-783-4476