pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

SUPPLEMENTAL AGREEMENT FOR COMPENSATION FOR DISABILITY OR PERMANENT INJURY

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

___ - ___ - ____ _____

DATE OF INJURY

__ - __ - ____
MM DD YYYY

WCAIS CLAIM NUMBER

_____

EMPLOYEE

First name _____

Last name _____

Date of birth _____

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 _____

County _____

Telephone _____ FEIN _____

Contact _____

NAIC code _____ or Insurer code _____

Insurer/TPA claim # _____

INJURY INFORMATION

Part of body injured _____

Nature of injury

Accident/injury description narrative

Check if occupational disease ☐

NOTICE: Agreement should be clearly completed, preferably typed, and uploaded in accordance with the provisions of the EDI Implementation Guide. A copy must be sent to the dependent/guardian/personal representative. Wage information must be completed in accordance with Section 309 of the Pennsylvania Workers' Compensation Act and sent to the Dependent/Guardian/Personal Representative.

Whereas, the undersigned employer and employee hereby agree that the status of the employee's disability changed on

__ - __ - ____ as follows:
MM DD YYYY

☐ Suspended, returned to work, no loss of wages
☐ Modification
☐ Specific loss
☐ Termination
☐ Recurred

Said employer shall pay employee compensation at the rate of $_____ per week beginning on __ - __ - ____
MM DD YYYY

Compensation is payable for _____ weeks _____ days; or, if the future period of disability is uncertain, then to continue at said-rate until further changed by supplemental agreement, final receipt, or order of a Workers' Compensation Judge, or the Workers' Compensation Appeal Board.

The employee's new partial compensation is based on the employee's present weekly earnings and is calculated as follows:

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)

Further matters agreed upon (list any previously unreported periods of compensation and/or actions in chronological order, as well as additional information):

We, the undersigned, agree upon the matters represented herein by the above named employee and the above named employer.

Date of agreement

		–			–				
MM			DD			YYYY			

_____

Employee's signature

_____

Employer/Insurer Representative's signature

_____

Employer/Insurer Representative's name (typed/printed)

_____

Employer/Insurer Representative's telephone number

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services	**Claims Information Services**	**Hearing Impaired**	**Email**
717.772.3702	toll-free inside PA: 800.482.2383 local & outside PA: 717.772.4447	PA Relay 7-1-1	ra-li-bwc-helpline@pa.gov

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