

**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 _____

INJURY INFORMATION

Part of body injured _____
 Nature of injury _____

 Accident/injury description narrative _____

 Check if occupational disease

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 # _____

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

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MM DD YYYY

as follows:

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

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.

Employee's signature

Date of agreement

		-			-				
MM			DD			YYYY			

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
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
PA Relay 7-1-1

Email
ra-li-bwc-helpline@pa.gov

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