pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

SUPPLEMENTAL AGREEMENT FOR COMPENSATION FOR DEATH

DECEASED'S SOCIAL SECURITY NUMBER OR WC ID NUMBER

___ - ___ - ____ _____

DATE OF INJURY (MM - DD - YYYY)

__ - __ - ____

WCAIS CLAIM NUMBER

_____

DECEASED EMPLOYEE

First name _____

Last name _____

Date of birth __ - __ - ____ (MM - DD - YYYY)

Date of death __ - __ - ____ (MM - DD - YYYY)

DEPENDENT/GUARDIAN/PERSONAL REPRESENTATIVE

First name _____

Last name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____ Telephone _____

INJURY INFORMATION

Part of body injured _____

Nature of injury

Accident/injury description narrative

Check if occupational disease ☐

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 # _____

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.

We, the following persons, dependents of the aforementioned deceased employee, and the undersigned employer, are parties to a compensation agreement or award which is changed because on __ - __ - ____ (MM - DD - YYYY)

the dependent, _____

☐ Died ☐ Remarried ☐ A posthumous child was born ☐ Other _____

It is now agreed that compensation shall be payable as follows:

WEEKLY RATE	FROM MM-DD-YYYY	THROUGH MM-DD-YYYY	#WEEKS/#DAYS	REASON FOR CHANGE	AMOUNT
$					$
$					$
$					$
$					$
$					$
$					$
$					$

The above compensation shall be payable from ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY) to ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY).

Further matters agreed upon:

Date of this agreement ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY)

Dependent/Guardian/Personal Representative's signature

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

Employer/Insurer Representative's signature

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