pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
WORKERS' COMPENSATION OFFICE OF ADJUDICATION

PETITION FOR COMMUTATION

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 _____

VS. 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

Provide the following information if Employer has accepted liability for this injury:

Part of body injured _____

Nature of injury _____

_____

_____

Accident/injury description narrative _____

_____

_____

Check if occupational disease ☐

Compensation Presently Payable Under:

☐ Notice of Compensation Payable ☐ Agreement
☐ Supplemental Agreement ☐ Award

TO YOUR HONORABLE JUDGE:

I, _____ ☐ employee ☐ dependent or guardian ☐ employer

hereby petitions your honorable Judge to commute the sum of $ _____ . __ representing future installments of compensation payable in the captioned case, as provided under Section 316 of the Pennsylvania Workers' Compensation Act, and to order payment of said compensation in one lump sum to _____ at its then value discounted at five (5) percent interest for the following reasons:

_____

_____

_____

_____

PLEASE ENTER MY APPEARANCE FOR PETITIONER:

Attorney's name _____

PA Attorney ID number _____

Firm name _____

Address _____

Address _____

City/Town _____ State _____ ZIP _____

Telephone _____

_____

Petitioner or Representative's signature

Date of petition

☐☐ - ☐☐ - ☐☐☐☐

MM DD YYYY

_____

Petitioner or Representative's name (typed/printed)

Notice: This petition must be filled out as fully as possible. If not filing electronically, the original must be sent to the Workers' Compensation Office of Adjudication, 1010 N. Seventh St, Suite 202, Harrisburg, PA, 17102-1400. You must send a copy to all other parties, and to the attorneys of all other parties, if the attorneys are known. A Proof of Service must be attached. A Proof of Service is a signed statement signed by you verifying that you have sent a copy of the petition to all parties and their attorneys, if known. Questions regarding the completion of this form may be directed to the Bureau of Workers' Compensation Claims Information Services.

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