pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

AGREEMENT TO STOP WEEKLY WORKERS' COMPENSATION PAYMENTS FINAL RECEIPT

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 _____

Specialty _____

Contact _____

NOTICE TO EMPLOYEE

Signing this form means your weekly workers' compensation payments will stop. You may file a petition to reopen your claim within three years of the date to which payments were made.

SIGN THIS FORM IF: Beginning and ending dates and total amount paid shown below are correct; AND you have fully recovered from your injury or disease.

DO NOT SIGN THIS FORM IF: You have returned to work, but are earning less due to work related injury; OR your employer or the insurance company is withholding your last workers' compensation check unless you sign this form.

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.

The employee received from the above named EMPLOYER/INSURER the sum of $ _____ as final payment of compensation due under the Pennsylvania Workers' Compensation Act for the injury or disease incurred in the above case. The total amount of compensation received, including the final payment above, is $ _____ in disability benefits for wage loss covering a period of _____ weeks _____ days from the date disability began on ___ - ___ - ____ (MM DD YYYY) until the employee was able to return to work on ___ - ___ - ____ (MM DD YYYY) without loss of earning power due to the injury or disease incurred.

Notice: The employer/insurance company hereby agrees that no representations have been made to the employee other than those contained in this agreement and that this complies with the Workers' Compensation Act and Rules and Regulations.

Employee's signature

Employer/Insurer Representative's signature ___ - ___ - ____ (MM DD YYYY)

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