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

DEFENDANT'S ANSWER TO CLAIM PETITION UNDER PENNSYLVANIA OCCUPATIONAL DISEASE ACT

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 _____ Date of death _____

If deceased - Dependent/Guardian/Personal Representative

First name _____

Last name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____ Telephone _____

EMPLOYER

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

VS. INSURER, FUND 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 # _____

And
Commonwealth of Pennsylvania
Department of Labor & Industry
Harrisburg, PA 17104-2501

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 ☐

"FUND" SHALL MEAN THE UNINSURED EMPLOYERS GUARANTY FUND, SUBSEQUENT INJURY FUND, SELF-INSURANCE GUARANTY FUND OR PRE-SELF-INSURANCE GUARANTY FUND.

TO YOUR HONORABLE JUDGE:

In answer to the captioned claim, the defendant respectfully pleads as follows: (Answers must be identified by numerical order in direct response to corresponding numbered allegations asserted in the claim petition.)

As a matter of further defense, the defendant states the following:

PLEASE ENTER MY APPEARANCE FOR DEFENDANT:

Attorney's name _____
PA Attorney ID number _____
Firm name _____
Address _____
Address _____
City/Town _____ State _____ ZIP _____
Telephone _____

Date filed
__ __ - __ __ - __ __ __ __
MM DD YYYY

_____ _____
Attorney's signature Attorney's name (typed/printed)

_____ _____
Defendant's signature Defendant's name (typed/printed)

Notice: This answer 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 unrepresented parties and to the attorney of record for all parties which are represented by counsel. A Proof of Service must be attached. A Proof of Service is a signed statement by you verifying that you have sent a copy of the answer to all parties and their attorneys, if known. Answers must be filed within 20 days of the assignment in of the petition. Every fact alleged in the petition not specifically denied by this answer shall be deemed to be admitted. 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