

## FINAL STATEMENT OF ACCOUNT OF COMPENSATION PAID

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

[ ]	[ ]	-	[ ]	-	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
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DATE OF INJURY

[ ]	-	[ ]	-	[ ]	[ ]	[ ]	[ ]
MM		DD		YYYY			

WCAIS CLAIM NUMBER

[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
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**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 _____

**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:** A Final Statement of Account shall be filed after the final payment of compensation.

This is to certify that the above named employer or insurer has paid compensation under the Pennsylvania Workers' Compensation Act in the above case as follows:

Rate	From Date	To Date	#Wks	#Days	Total
\$ _____	[ ] [ ] - [ ] [ ] - [ ] [ ] [ ] [ ]	[ ] [ ] - [ ] [ ] - [ ] [ ] [ ] [ ]	_____	_____	\$ _____
	MM DD YYYY	MM DD YYYY			
\$ _____	[ ] [ ] - [ ] [ ] - [ ] [ ] [ ] [ ]	[ ] [ ] - [ ] [ ] - [ ] [ ] [ ] [ ]	_____	_____	_____
	MM DD YYYY	MM DD YYYY			
\$ _____	[ ] [ ] - [ ] [ ] - [ ] [ ] [ ] [ ]	[ ] [ ] - [ ] [ ] - [ ] [ ] [ ] [ ]	_____	_____	_____
	MM DD YYYY	MM DD YYYY			

\*Additional payment periods or remarks should be indicated on the reverse side of this form.

Medical Payments	\$ _____
Indemnity Payments	\$ _____
Other Payments	\$ _____
<b>TOTAL COMPENSATION PAID</b>	<b>\$ _____</b>

Remarks/Additional Information:

\_\_\_\_\_  
Employer/Insurer Representative signature

\_\_\_\_\_  
Employer/Insurer Representative (typed/printed)

Date

	-		-				
MM		DD		YYYY			

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