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

CLAIM PETITION FOR BENEFITS FROM THE UNINSURED EMPLOYER AND THE UNINSURED EMPLOYERS GUARANTY FUND

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 _____

If Deceased - Dependent/Guardian/Personal Representative

First name _____

Last name _____

Address _____

Address _____

City/Town _____ State____ ZIP_____

County _____

Telephone _____

VS

EMPLOYER

Name _____

Address _____

Address _____

City/Town _____ State____ ZIP_____

County _____

Telephone _____ FEIN _____

AND

Pennsylvania Uninsured Employers Guaranty Fund
1171 S. Cameron St.
Harrisburg, PA 17104

Employee should file this petition if they are seeking an award against their employer and the Uninsured Employers Guaranty Fund because their employer did not maintain workers' compensation insurance coverage or was not approved as a self-insurer at the time of the alleged injury. Note: You may not file this petition until 21 days after you filed a Notice of Claim Against Uninsured Employer, Form LIBC-551.

1. Have you filed a Notice of Claim Against the Uninsured Employer, Form LIBC-551? ☐ Yes ☐ No
2. Complete description of injury or illness including all parts of body affected. If fatality, provide cause of death.

   _____
3. If occupational disease, give the last date of employment __ (MM) - __ (DD) - ____ (YYYY) and/or last date of exposure __ (MM) - __ (DD) - ____ (YYYY)
4. Give date of injury or onset of disease __ (MM) - __ (DD) - ____ (YYYY)
5. How did the injury or disease occur?
6. Did injury or disease occur on employer's premises? ☐ Yes ☐ No Where? (Be specific)

   _____
7. Notice of your injury or disease was served on your employer on __ (MM) - __ (DD) - ____ (YYYY) in the following manner:

   _____
8. Did this problem cause you to stop working? ☐ Yes ☐ No If yes, give date. __ (MM) - __ (DD) - ____ (YYYY)
9. What was your job title at the time of injury or disease? _____
10. Are you back to work with the same employer? ☐ Yes ☐ No If yes, ☐ Regular job ☐ Other job/give title _____
11. Are you working with another employer? ☐ Yes ☐ No If yes, give name and address of new employer:

12. What were your weekly wages at the time of injury? $ ____ . ____

13. Were you working for more than one employer at the time of the injury? ☐ Yes ☐ No If yes, list additional employers:

_____

14. If you have returned to work since your injury or illness, what are your weekly wages? $ ____ . ____

15. Dependents/Guardians/Personal Representatives are as follows:

NAME	ADDRESS	DATE OF BIRTH MM-DD-YYYY	RELATIONSHIP	US CITIZEN
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

16. I am seeking payment for (check all that apply):

☐ Loss of Wages

☐ Partial disability from MM - DD - YYYY to MM - DD - YYYY ☐ ongoing

☐ Full disability from MM - DD - YYYY to MM - DD - YYYY ☐ ongoing

☐ Medical bills (give name of doctor/hospital, address, type of treatment and bill in space below.)

☐ Counsel fees to be paid by the employer. (Note: The Fund is not subject to unreasonable contest attorney fees.)

☐ Loss or loss of use of arm, hand, finger, leg, foot or toe.

☐ Disfigurement (scars) of head, face or neck.

☐ Injury or disease resulting in death. Date of death. MM - DD - YYYY

☐ Loss of sight

☐ Loss of hearing

☐ Cancer as a firefighter under Act 46 of 2011

☐ Other _____

17. Have you filed any other Workers' Compensation Petition(s) related to this injury/fatality? ☐ Yes ☐ No

If yes, PA BWC Claim Number (if known) _____.

PLEASE ENTER MY APPEARANCE FOR PETITIONER:

Attorney's name _____

PA attorney ID number _____

Firm name _____

Address _____

Address _____

City/Town _____ State _____ ZIP _____

Telephone _____

Date of petition

MM - DD - YYYY

A copy of this petition has been sent to the employer and the Fund.

_____

Signature

☐ Employee or Dependent ☐ Attorney

Notice: A Claim Petition for Benefits from the Uninsured Employer and the Uninsured Employer's Guaranty Fund can be filed electronically by logging into WCAIS at www.WCAIS.pa.gov. If not filing electronically, a paper Claim Petition for Benefits from the Uninsured Employer and the Uninsured Employer's Guaranty Fund, Form LIBC-550, must be sent to the Workers' Compensation Office of Adjudication, 1010 N. Seventh St, Suite 202, Harrisburg PA 17102-1400. This petition must be filled out as fully as possible. You must send a copy of this petition to the employer. Questions may be directed to Workers' Compensation Office of Adjudication.

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).

Workers' Compensation Office of Adjudication
844.237.6316
WCOAResourceCenter@pa.gov

Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA TTY: 800.482.2383
local & outside PA TTY: 717.772.4447

Hearing Impaired
PA Relay 7-1-1

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program