pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

NOTICE OF CLAIM AGAINST UNINSURED EMPLOYER

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER ___ - ___ - ____ _____

DATE OF INJURY ___ - ___ - ____ (MM DD YYYY)

WCAIS CLAIM NUMBER _____

Instructions: A Notice of Claim Against Uninsured Employer can be filed electronically by logging into WCAIS at www.WCAIS.pa.gov or by completing and mailing form LIBC-551. When filing by paper, all questions in bold print must be completed, the form must be signed by the employee or his/her counsel, and it must be mailed to the Workers' Compensation Office of Adjudication, 1010 N. Seventh St, Suite 202, Harrisburg, PA 17102-1400. If you have submitted a Notice electronically, a paper Notice should not be mailed. Forms filed electronically in WCAIS, or completed properly and mailed to the aforementioned address, will constitute notice to the Fund pursuant to section 1603(b) of the Pa. Workers' Compensation Act, 77 P.S. § 2703(b) once they have been accepted. A Claim Petition for Benefits from the Uninsured Employers Guaranty Fund (Form LIBC-550) may be filed 21 days after the Notice is accepted. Questions may be directed to the Workers' Compensation Office of Adjudication.

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 _____

Owner/Contact _____

Injury

At what address did the injury occur: _____ **City:** _____ **State:** _____ **ZIP:** _____

Describe the incident and injury, include body parts affected or the cause of death: _____

_____

_____

_____

Was the injury reported to the employer? ☐ **Yes** ☐ **No** **If yes, the two questions below MUST be answered:**

If yes, when? _____ To whom? _____

Time of injury: _____ ☐ **AM** ☐ **PM** **Did the injury result in a fatality?** ☐ **Yes** ☐ **No**

If the injury resulted in a fatality, provide the following dependent, guardian, executor, or estate information:

Name _____

Address _____

Telephone _____ Relationship _____

Disability

Occupation/Job Title: _____

List the employee's gross weekly wages at the time of injury: _____

Last day worked ___ - ___ - ____ (**MM DD YYYY**) **Hours worked per week:** _____

Did the injury cause a loss of wages? ☐ **Yes** ☐ **No** **Has the employer been paying for lost wages?** ☐ **Yes** ☐ **No**

ATTACH MOST RECENT PAY STATEMENT OR CHECK/STUB OR OTHER PROOF OF WAGES

Has the employee returned to work? ☐ **Yes** ☐ **No** **If yes, the four questions below MUST be answered:**

Date of return: _____

How much is the employee earning? Rate: $_____ Per: Hour, Week, Biweekly, Month (circle)

Is the employment with the same employer ☐ Yes ☐ No

Employer information: _____

(Please give name, address, and telephone number)

Medical

Has the employee sought medical treatment for the work injury? ☐ **Yes** ☐ **No**

Has the employer paid for medical treatment for the work injury? ☐ **Yes** ☐ **No**

List Doctors/Medical Facilities and their addresses: (Attach additional sheets, if necessary.)

_____

_____

DESIGNATED PANEL PROVIDER NOTIFICATION The Uninsured Employers Guaranty Fund (UEGF) has established a list of panel providers as permitted by section 1603(e) of the PA Workers' Compensation Act. As such, during the 90-day period from the date of the employee's Form LIBC-551, Notice of Claim Against Uninsured Employer, the UEGF is only responsible to reimburse expenses for medical treatments, services and accommodations rendered by the physicians or other health care providers that are designated on the list. If the employee receives medical treatments, services or accommodations from a health care provider that is not designated on the list during this 90-day period, the UEGF is relieved from liability for the payment of the medical treatments, services and accommodations rendered during that time. The list of designated providers is available at www.dli.pa.gov/Businesses/Compensation/WC/uegf or by contacting the Bureau's Helpline at 800-482-2383.

VERIFICATION

By signing below, I verify that all information submitted on this form is, to the best of my knowledge, information and belief, true, complete, and correct. I understand that any individual who knowingly and with the intent to defraud, files misleading or incomplete information is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to civil and criminal penalties, including prosecutions under 18 Pa. C.S.A. §4903 (relating to false swearing).

PLEASE ENTER MY APPEARANCE (if applicable):

Attorney's name: _____

PA Attorney ID number: _____

Firm name: _____

Address: _____

Address: _____

City/Town: _____ State: _____ ZIP: _____

Telephone: _____

Date of Notice

☐☐ - ☐☐ - ☐☐☐☐

MM **DD** **YYYY**

_____ _____ _____

ATTORNEY'S/EMPLOYEE'S, IF UNREPRESENTED, SIGNATURE **TELEPHONE** **DATE**

The injured employee (or dependent, if the employee is deceased) must complete and sign the following authorization, which the Uninsured Employers Guaranty Fund may use to collect records relating to medical treatment that the injured or deceased employee received and to collect wage information from the injured or deceased employee's current or previous employer(s).

AUTHORIZATION TO RELEASE INFORMATION/VERIFICATION OR INFORMATION

To Whom It May Concern:

By signing below, I hereby request and authorize you to furnish to the Pennsylvania Uninsured Employers Guaranty Fund, or its representative(s), any and all information you have concerning the above-named employee with respect to any illness or injury, medical history, consultation, treatment, including x-rays, as well as copies of all hospital or medical records, military records, or other government records.

I further request and authorize employers to furnish complete information concerning wages, commissions, and the like. By signing below, I attest that I am the employee identified above, or that I am the deceased employee's dependent authorized to request the release of such records, and that I am pursuing a claim for benefits under the Pennsylvania Workers' Compensation Act.

Should entities subsequently refuse to honor this Notice's Authorization for any reason, employee/dependent hereby further agrees, upon request by the UEGF, to physically sign and authorize any subsequently provided Authorization form necessary to obtain these records.

A photocopy of this authorization shall be considered as effective and valid as the original authorization.

Signature _____ **Date** _____

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	**Employer Information Services**	**Claims Information Services**	**Hearing Impaired**
844.237.6316 WCOAResourceCenter@pa.gov	717.772.3702	toll-free inside PA: 800.482.2383 local & outside PA: 717.772.4447	PA Relay 7-1-1

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