

**EMPLOYEE'S REPORT OF
BENEFITS FOR OFFSETS**
(UNEMPLOYMENT COMPENSATION, SOCIAL SECURITY [OLD AGE],
SEVERANCE AND PENSION BENEFITS)

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

| | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| X | X | X | - | X | X | - | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|

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 _____

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 _____
 NAIC code _____ or Insurer code _____
 Insurer/TPA claim # _____

READ THE INSTRUCTIONS ON THE REVERSE SIDE BEFORE COMPLETING THIS FORM.

Section 204 of the Workers' Compensation Act requires employees receiving wage-loss benefits to report the receipt of unemployment compensation, social security (old age) benefits, severance and pension benefits.

COMPLETE AND RETURN THIS FORM TO THE INSURER OR SELF-INSURED EMPLOYER IDENTIFIED ON THIS FORM.

Complete the following information, indicating the type, amount and frequency (i.e.: weekly, biweekly, or other [specify]) of the benefits being received. Include the date such receipt began and ended (if applicable). If you are not receiving a particular type of benefit, indicate by writing "not applicable" or "none" in the appropriate space.

| TYPE OF BENEFIT | AMOUNT RECEIVED | FREQUENCY | RECEIPT BEGAN | RECEIPT ENDED |
|---------------------------|------------------------|---|----------------------|----------------------|
| | | | DATE (MM/DD/YYYY) | DATE (MM/DD/YYYY) |
| Unemployment Compensation | Gross \$ _____ . _____ | <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly | ____ / ____ / ____ | ____ / ____ / ____ |
| | Net \$ _____ . _____ | <input type="checkbox"/> Other _____ | | |
| Social Security (old age) | Gross \$ _____ . _____ | <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly | ____ / ____ / ____ | ____ / ____ / ____ |
| | Net \$ _____ . _____ | <input type="checkbox"/> Other _____ | | |
| Severance | Gross \$ _____ . _____ | <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly | ____ / ____ / ____ | ____ / ____ / ____ |
| | Net \$ _____ . _____ | <input type="checkbox"/> Other _____ | | |
| Pension | Gross \$ _____ . _____ | <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly | ____ / ____ / ____ | ____ / ____ / ____ |
| | Net \$ _____ . _____ | <input type="checkbox"/> Other _____ | | |

If you are receiving pension benefits from the employer directly liable for your workers' compensation, indicate the percent of the pension which is funded by the employer or check the box for 'percentage unknown'.

_____ % Percentage unknown

Did you "roll over" pension benefits into an IRA Account? Yes No Amount "rolled over" \$ _____ . _____
(IRA benefits are not offset until you begin withdrawing them from your account.)

I verify that this information is true and correct, based upon my knowledge, information and belief. I understand false statements are subject to the penalties of 18 Pa. C.S. §4909, relating to unsworn falsification to authorities.

Employee signature

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

If you are receiving any wages from employment or self-employment, check this box . You must report this to your insurer or self-insured employer.

INSTRUCTIONS

TO EMPLOYEES:

If you are receiving workers' compensation wage-loss benefits due to an injury which occurred on or after June 24, 1996, you must report the receipt of the following:

- Unemployment compensation benefits
- Social Security (old age) benefits
- Severance benefits paid by the employer directly liable for your workers' compensation
- Pension benefits to the extent funded by the employer directly liable for your workers' compensation

Your workers' compensation benefits may be adjusted if you are receiving any of the above benefits. You are required to acknowledge both the receipt of and changes to any of the benefits listed above through the immediate completion and submission of this form.

FAILURE TO REPORT THE RECEIPT OF OR CHANGES TO ANY OF THE BENEFITS LISTED ABOVE MAY SUBJECT YOU TO PROSECUTION UNDER ARTICLE XI OF THE WORKERS' COMPENSATION ACT RELATING TO INSURANCE FRAUD.

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