pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

EMPLOYEE VERIFICATION OF EMPLOYMENT, SELF-EMPLOYMENT OR CHANGE IN PHYSICAL CONDITION

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 # _____

INSTRUCTIONS TO EMPLOYEE:

DO NOT RETURN THIS FORM TO THE BUREAU OF WORKERS' COMPENSATION.

COMPLETED FORM MUST BE RETURNED TO THE PARTY WHO SENT THE FORM TO YOU WITHIN 30 DAYS OF YOUR RECEIPT OF THIS FORM.

IF YOU DO NOT COMPLETE AND RETURN THIS FORM TO THE PARTY WHO SENT IT TO YOU WITHIN 30 DAYS IT MAY RESULT IN A SUSPENSION OF YOUR COMPENSATION BENEFITS AS PROVIDED BY SECTION 311.1(g) OF THE WC ACT, AS WELL AS PROSECUTION FOR FRAUD UNDER ARTICLE XI OF THE WC ACT.

YOU MAY BE REQUIRED TO COMPLETE AND RETURN THIS FORM EVERY SIX MONTHS.

INSTRUCTIONS TO EMPLOYEE: Section 311.1(d) of the Workers' Compensation Act requires employees who are receiving workers' compensation, or have filed a petition to receive workers' compensation, to verify employment, self-employment, wages and changes to physical condition.

1. Are you currently employed by any employer other than the employer listed above? ☐ Yes ☐ No

2. Are you currently self-employed? ☐ Yes ☐ No

3. Have you been employed or self-employed at any time while receiving workers' compensation benefits? ☐ Yes ☐ No

4. Has your physical condition (caused by your injury) changed? ☐ Yes ☐ No

5. Is there other information you are aware of that is relevant in determining your entitlement to, or amount of compensation? ☐ Yes ☐ No

(OVER)

6. Names of employers for whom you have worked since your date of injury:

Name ____________________
Address ____________________
Address ____________________
City/Town ____________ State ____ ZIP ________
Period of employment:
From [ ][ ] - [ ][ ] - [ ][ ][ ][ ]
MM DD YYYY
To [ ][ ] - [ ][ ] - [ ][ ][ ][ ]
MM DD YYYY
Amount of wages $ ________

Name ____________________
Address ____________________
Address ____________________
City/Town ____________ State ____ ZIP ________
Period of employment:
From [ ][ ] - [ ][ ] - [ ][ ][ ][ ]
MM DD YYYY
To [ ][ ] - [ ][ ] - [ ][ ][ ][ ]
MM DD YYYY
Amount of wages $ ________

Name ____________________
Address ____________________
Address ____________________
City/Town ____________ State ____ ZIP ________
Period of employment:
From [ ][ ] - [ ][ ] - [ ][ ][ ][ ]
MM DD YYYY
To [ ][ ] - [ ][ ] - [ ][ ][ ][ ]
MM DD YYYY
Amount of wages $ ________

IF SELF-EMPLOYED

From [ ][ ] - [ ][ ] - [ ][ ][ ][ ]
MM DD YYYY
To [ ][ ] - [ ][ ] - [ ][ ][ ][ ]
MM DD YYYY
Amount of wages $ ________

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. §4904 relating to unsworn falsification to authorities.

Employee

First name ____________________
Last name ____________________
Signature ____________________

DATE OF NOTICE
[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
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