pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

NOTIFICATION OF SUSPENSION OR MODIFICATION PURSUANT TO §§ 413 (c) & (d)

DATE OF NOTIFICATION
MM - DD - YYYY

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 _____
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

This form must be completed, notarized and either uploaded in WCAIS or mailed to the Bureau of Workers' Compensation (BWC), 1171 South Cameron Street, Room 103, Harrisburg, PA 17104-2501. This form must be mailed to the employee and filed with BWC within seven days of a suspension or modification of benefits under the provisions of the Workers' Compensation Act.

You are notified that because you returned to work on MM - DD - YYYY, your weekly disability benefits for this injury have been:

☐ Suspended effective MM - DD - YYYY because you have returned to work at earnings equal to or greater than your time-of-injury earnings of $_____.

OR

☐ Modified to the rate of $_____ per week, effective MM - DD - YYYY because you returned to work at earnings less than your time-of-injury earnings.

INSURER'S AFFIDAVIT

I attest or affirm that the statements contained herein are true and correct to the best of my knowledge, information and belief.

affix seal here

_____
Claims representative's signature

_____
Claims representative's name (typed/printed)

_____
Phone number

SUBSCRIBED AND SWORN TO (OR AFFIRMED) BEFORE ME THIS _____ DAY OF _____, _____

_____
Signature of notary

NOTE TO EMPLOYEE: If you do not agree with this action and wish to challenge it, please read the instructions under EMPLOYEE CHALLENGE on the back of this form.

Weekly wages must be computed in accordance with the Pennsylvania Workers' Compensation Act.

CALCULATION for partial compensation rate (to be completed for modification). The employee's new partial compensation rate is based on the claimant's present weekly earning and is calculated as follows:

Calculation: _____ Average weekly wage at time of injury

minus: _____ Present weekly earnings

_____ Subtotal

x 2/3 = _____ New partial compensation rate
(Subject to the maximum benefit)

EMPLOYEE CHALLENGE:

If you do not agree with this action, you must challenge it within (20) days of the date you receive this notice. Challenge it online at www.WCAIS.pa.gov. Choose file petition action, choose challenge and the claim number you want to challenge. In the alternative, you may challenge by checking the box below, signing this form and mailing it to the Pennsylvania Department of Labor & Industry, Workers' Compensation Office of Adjudication (WCOA), 1010 N 7th Street, Suite 201, Harrisburg, PA 17102-1400. This material must be filed with the (WCOA) within (20) days from the date you received it.

If you do not challenge this action within (20) days of the date you receive this notice, you will be deemed to have admitted that you agree with the action taken on this form. In that case, this notice will have the same binding effect as a fully executed Supplemental Agreement for the suspension or modification of benefits.

☐ I do not agree with the action taken by my employer. I request a special supersedeas hearing (a hearing on whether my workers' compensation benefits can be reduced or stopped) before a Workers' Compensation Judge. A hearing is requested to be conducted in accordance with Sections 413 (c) & (d) of the Pennsylvania Workers' Compensation Act.
(if the employee has legal counsel, complete below.)

Attorney's name _____

PA attorney ID# _____

Name of firm _____

Address _____

Address _____

City/Town _____ State ___ ZIP _____

Telephone _____

Employee's signature _____

Address _____

Address _____

City/Town _____ State ___ ZIP _____

County _____

Telephone _____
(Employee to complete if different from information provided by employer)

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	**Claims Information Services**	**Hearing Impaired**	**Email**
717.772.3702	toll-free inside PA: 800.482.2383 local & outside PA: 717.772.4447	toll-free inside PA TTY: 800.362.4228 local & outside PA TTY: 717.772.4991	ra-li-bwc-helpline@pa.gov

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