pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

NOTICE STOPPING TEMPORARY COMPENSATION

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 # _____

DATE OF THIS NOTICE (MM - DD - YYYY)

NOTICE TO EMPLOYEE: This notice is being sent because payment of compensation, being paid pursuant to the Notice of Temporary Compensation Payable, is being stopped as of (MM - DD - YYYY).

The payment of temporary compensation does not mean that your employer assumed responsibility for your injury. Your employer and you retain all rights, defenses and obligations with regard to the claim. Further, the payment of temporary compensation may not be used to support a claim for benefits in a future proceeding.

☐ WE HAVE ACCEPTED RESPONSIBILITY FOR YOUR CLAIM, AND ATTACHED IS A *NOTICE OF COMPENSATION PAYABLE* OR AN *AGREEMENT FOR COMPENSATION*; **OR**

☐ WE HAVE DECIDED NOT TO ACCEPT LIABILITY, AND ATTACHED IS A *NOTICE OF WORKERS' COMPENSATION DENIAL.* IF YOU BELIEVE YOU SUFFERED A WORK-RELATED INJURY, YOU WILL BE REQUIRED TO FILE A CLAIM PETITION WITH THE WORKERS' COMPENSATION OFFICE OF ADJUDICATION IN ORDER TO PROTECT YOUR FUTURE RIGHTS.

You have three years from the date of injury or discovery of your condition to file a Claim Petition for benefits. Since time limits can vary depending on the facts of your situation, you may wish to contact an attorney if you believe you may have a claim.

Authorized Agent for Insurer or TPA (if self-insured) _____

Claims Representative's signature _____

Claims Representative's name (typed/printed) _____

Telephone _____

NOTICE TO INSURER: This form must be either electronically filed in WCAIS or mailed to the Bureau of Workers' Compensation, 1171 South Cameron Street, Room 103, Harrisburg, PA 17104-2501 no later than five days after the last payment of temporary compensation. A copy must be sent to the employee.

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