COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 S. CAMERON STREET, ROOM 103
HARRISBURG, PA 17104-2501
(TOLL FREE) 800-482-2383

SUPPLEMENTAL AGREEMENT FOR COMPENSATION FOR DISABILITY OR PERMANENT INJURY

EMPLOYEE SOCIAL SECURITY NUMBER

DATE OF INJURY

MONTH DAY YEAR

PA BWC CLAIM NUMBER (IF KNOWN)

John T. Hofrichter & Associates

EMPLOYEE

First Name
Last Name
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
Telephone ( ) Bureau Code
County
Claim # FEIN

INJURY INFORMATION

Body Part(s) affected
Type of Injury
Description of Injury

Check if Occupational Disease

Whereas, the undersigned employer and employee are parties to a compensation agreement or award and it is now hereby agreed between parties hereto that the status of the disability of the said employee changed

on MONTH DAY YEAR as follows: Suspended; Returned to work, No Loss of Wages | Termination
Modification | Recurred
Specific Loss

Said employer shall pay said employee compensation at the rate of $ per week beginning on MONTH DAY YEAR

Compensation payable for weeks days, or, if the future period of disability is uncertain, then to continue at said rate until further terminated by supplemental agreement, final receipt, or order of a Workers' Compensation Judge, or the Workers' Compensation Appeal Board.

NOTICE: Agreement should be clearly completed, (preferably typed) and original mailed to the Bureau at the address in the upper left corner and a copy to employee.

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NOTICE: Weekly wages must be computed in accordance with Section 309 of the Workers' Compensation Act

(OVER)

UBC-337 REV 11-97