

THIRD PARTY SETTLEMENT AGREEMENT

Social Security Number: _____ - _____ - _____

Date of Injury: ____ / ____ / ____
MM DD YYYY

PA BWC Claim Number: _____
(IF KNOWN)

Employee

First Name	Last Name	
_____	_____	
If Deceased - Dependent, Guardian	_____	
First Name	Last Name	
_____	_____	
Street 1	_____	
_____	_____	
Street 2	_____	
_____	_____	
City/Town	State	Zip Code
_____	_____	_____
County	Telephone	_____
_____	(____) _____	_____

Employer

Name	_____	
Street 1	_____	
_____	_____	
Street 2	_____	
_____	_____	
City/Town	State	Zip Code
_____	_____	_____
County	_____	_____
_____	_____	_____
Telephone	FEIN	_____
(____) _____	_____	_____

Employee's Attorney

Name	_____	
_____	_____	
Firm Name	_____	
_____	_____	
Street 1	_____	
_____	_____	
Street 2	_____	
_____	_____	
City/Town	State	Zip Code
_____	_____	_____
Telephone	PA Attorney ID Number	_____
(____) _____	_____	_____

Insurer or Third Party Administrator (if self-insured)

Name	_____	
Street 1	_____	
_____	_____	
Street 2	_____	
_____	_____	
City/Town	State	Zip Code
_____	_____	_____
Telephone	Bureau Code	_____
(____) _____	_____	_____
County	_____	_____
_____	_____	_____
Claim Number	FEIN	_____
_____	_____	_____

Insurer's Attorney

Name	_____	
_____	_____	
Firm Name	_____	
_____	_____	
Street 1	_____	
_____	_____	
Street 2	_____	
_____	_____	
City/Town	State	Zip Code
_____	_____	_____
Telephone	PA Attorney ID Number	_____
(____) _____	_____	_____

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