PMA COMPANIES

380 Sentry Parkway, Blue Bell, PA 19422 | T: 610.397.5000

Dear Valued Customer:

Please be advised that Section 306(f.1)(1)(i) of the Pennsylvania Workers' Compensation Act requires that an employer provide written notification to its employees of certain rights and duties. The employer must also ensure the employee understands these rights and duties, which is to be evidenced by the employee's signature on the Employee Notification, both at the time of hire and immediately after an injury.

Please note that proper utilization of this form, along with proper panel postings, means that an injured employee must treat within the panel for a period of ninety (90) days from the date of the first visit to a designated provider. The employer's failure to provide written notification relieves the employee of this obligation and he/she may treat with a provider of his/her choice. See Attached notice.

Should you have any questions regarding this communication, please contact your PMA representative at 1.888.476.2669.

Sincerely,

PMA Companies

Workers' Compensation is designed to provide wage loss benefits and reimbursement for reasonable medical care for employees injured on the job. Your employer is required to provide payment for reasonable surgical and medical services, services rendered by physicians or other healthcare providers, medicines and supplies, as and when needed.

Your employer, pursuant to the Workers' Compensation Act, has posted a list of at least six medical providers from which you are to select. You are to obtain treatment for work related injuries and illnesses from one or more of the designated healthcare providers on the posted list of your choice for ninety (90) days from the date of your first visit to a designated provider. If you do not seek treatment from a provider on the panel list for 90 days following the first visit to a designated provider, your employer will not have to pay for the services rendered.

If you are faced with an immediate medical emergency, you may seek treatment from a provider of your choice. Subsequent nonemergency treatment shall be by a designated provider for the remainder of the 90 day period.

You have the right, during the 90 day period, to switch from one healthcare provider on the list to another provider on the list, and such treatments shall be paid for by your employer

You have the right to seek treatment or medical consultation from a non-designated provider during the 90 day period, but these services shall be at your expense for the applicable 90 days.

If one of the listed providers prescribes invasive surgery, you are entitled to seek an additional opinion from any healthcare provider of your choice. If the additional opinion differs from the opinion of the designated provider and the additional opinion provides a specific and detailed course of treatment, you shall determine which course of treatment to follow. If you opt to follow the course of treatment outlined by the additional opinion, the treatment shall be performed by one of the healthcare providers on the designated list for 90 days from the date of the first visit to the provider of the additional opinion.

After the initial 90 day period, if additional continued treatment is needed, you may choose to go to another physician or healthcare provider of your choice. Should you decide to change providers, you must notify your employer within five (5) days of your first visit with your new provider. Failure to notify your employer will relieve your employer of the responsibility for the payment of the services rendered if such services are determined to have been unreasonable or unnecessary.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any facts material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I hereby acknowledge that I have been informed of and understand my rights and duties under the Workers' Compensation Act.

_____ _____

Employee Signature **Date**

WORKERS' COMPENSATION EMPLOYEE NOTIFICATION