FORM PY-01

Petition for Supplementary Order on Payment Default

<u>Instructions:</u> Pursuant to A.S.C.A. §32.0674, a compensation payment is considered a default if not paid by the employer or carrier within a period of 30-days after such compensation is due. To file a petition before the Commissioner for a supplementary order to declare a default, the employee must file this petition form with the Commissioner within one year after such default. Upon filing, the Commissioner has 45-days to investigate, notify, hear, and for the Commissioner to make a supplementary order declaring the amount in default which shall be filed as a compensation order.

3. Name of Employee (First, Middle, Last): 4. Name of Employer 5. Name of Carrier / Self-Insurer Employer: 6. Specify Benefit(s) Receiving Compensation declared for Payment Default: Temporary Wages / Earnings Permanent Impairment Installment payment? One-time Payment (specify how often payment is received): Death Benefits Permanent Impairment Installment Payment (specify how often payment is received): Death Benefits Received Received	1.	Date of this Notice:	2. Case No.:						
6. Specify Benefit (6) Receiving Compensation declared for Payment Default: Temporary Wages / Earnings Permanent Impairment Death Benefit / Reimbursement Death Benefit / Reimbursement Death Benefit / Reimbursement Others (specify):	2	2 Name of Employee (First Middle Last):		/ Name of Employer		5 Name of Carrier / Solf Incurer Employer			
Temporary Wages / Earnings Permanent Impairment Medical Benefit / Reimbursement Installment payment (specify how often payment is received): Weekly Beweekly Monthly Annually Monthly Annually Annual	3. Name of Employee (First, Middle, Last):		4. Name of Employer		J. Name	or carrier / Sett-msurer Employer.			
Permanent Impairment	6.	Specify Benefit(s) Receiving	Compensation declared fo						
Installment Payment (specify how often payment is received): Death Benefits Weekly Bi-weekly Monthly Annually Reversely Monthly Annually Remployee Dependents Remployee Dependent Remployee Remployee Dependent Remployee De									
Death Benefits Weekly Bi-weekly Monthly Annually	<u>'</u>								
Others (specify): Bi-weekly Monthly Annually									
8. Specify all persons or dependents (including the employee) whose payment(s) are under default: Name					1				
8. Specify all persons or dependents (including the employee) whose payment(s) are under default: Name		others (speeny).							
Name Employee / Dependents (Mon. / Day / Yr.) (Payment Past Due) Payment Due Date (Mon. / Day / Yr.) (Payment Past Due) Payment Past Due) 10. Indicate which person is signing this notice: Employee Dependent of the Employee Petitioner / Attorney on behalf of Employee 11. Authorization: I hereby verify and acknowledge as the Employee, Dependent, Petitioner or the representing Attorney on behalf of the employee or dependent, stated herein filing this form before the Commissioner of a supplementary order to declare a default payment by the employee or carrier for collection. I acknowledge that the Commissioner shall have 45-days to investigate, issue notice, and conduct hearings upon filing this form and not from make a supplementary order one deliberations are concluded. I duly affirmed that all the information, records, and documentations disclosed within and provided together with this form are both true and not fraudulent.									
Employee / Dependents (Mon. / Day / Yr.) (Payment Past Due) Amount Mon. / Day / Yr.) (Payment Past Due) Amount	8. Specify all persons or dependents (including the employee) whose payment(s) are under default:								
Employee / Dependents (Mon. / Day / Yr.) (Payment Past Due) Amount Mon. / Day / Yr.) (Payment Past Due) Amount	Name			Payment Due Date	Total Days		Total Payment		
Employee Dependent of the Employee Petitioner / Attorney on behalf of Employee	Employee / Dependents			=	(Payment Past Due)				
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		Authorized Signature							

FORM DISTRIBUTION:

- Original Commission
- Copy Employee / Beneficiary

FILED
*** AUTHORIZED OWCC PERSONNEL ONLY ***