pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
WORKERS' COMPENSATION OFFICE OF ADJUDICATION

FATAL CLAIM PETITION FOR COMPENSATION BY DEPENDENTS OF DECEASED EMPLOYEES

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 ____________ Date of death ____________

If deceased - Dependent/Guardian/Personal Representative

First name ____________________

Last name ____________________

Address ____________________

Address ____________________

City/Town ____________ State ____ ZIP ________

County ____________ Telephone ____________

U.S. Citizen ☐ Yes ☐ No

INJURY INFORMATION

Description of injury or illness ____________________

____

____

____

____

Check if occupational disease ☐

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 ____________

Contact ____________________

NAIC code ____________ or Insurer code ____________

Insurer/TPA claim # ____________________

1. Business of employer ____________________

2. Time of injury (hour) ____________ ☐ a.m. ☐ p.m.

3. The cause of death was ____________________ as given by ____________________

   ____

4. The deceased employee incurred the following medical bills (give name of health care provider, address, type of treatment and bill in space below) related to the fatality.

   ____
   GIVE NAME AND ADDRESSES. IF NONE, SO STATE.

5. Expenses for the burial amounted to $________ . ____ .

   Amount paid by employer $________ . ____ .

6. The wages of deceased employee at the time of accident were $________ . ____ . ☐ hour ☐ day ☐ week

7. Notice of injury and/or death was given to employer on ☐☐ - ☐☐ - ☐☐☐☐ (MM DD YYYY) by ____________________ (NAME OF PERSON REPORTING INJURY/DEATH)

   in the following manner ____________________
   STATE WHEN AND TO WHOM NOTICE WAS GIVEN AND IN WHAT MANNER

8. Compensation for disability was paid to the deceased from ☐☐ - ☐☐ - ☐☐☐☐ (MM DD YYYY) to ☐☐ - ☐☐ - ☐☐☐☐ (MM DD YYYY)

   Total amount paid was $________ . ____ .

9. Dependents are as follows:

NAME	ADDRESS	DATE OF BIRTH MM-DD-YYYY	RELATIONSHIP	US CITIZEN
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

10. Their dependency is ☐ total ☐ partial

11. Petitioner ☐ was ☐ was not living with the deceased employee at the time of his or her death.

12. The petitioner ☐ is ☐ is not a widow/widower of the deceased employee.

    a. If petitioner is a widow or widower, state where ceremony was performed and give date of marriage.

    b. Was marriage a common law marriage? ☐ Yes ☐ No

13. This is an Act 46 (firefighter cancer) claim ☐

14. Other ______________________________

15. Is there other pending litigation in this case ☐ Yes ☐ No If yes, explain below.

____

____

PLEASE ENTER MY APPEARANCE FOR PETITIONER:

Attorney's name ______________________________
PA Attorney ID number ______________________________
Firm name ______________________________
Address ______________________________
Address ______________________________
City/Town ______________ State ______ ZIP ____________
Telephone ______________________________

Date of petition
☐☐ - ☐☐ - ☐☐☐☐
MM DD YYYY

____
Attorney's signature

____
Dependent/Guardian/Personal Representative's signature

____
Dependent/Guardian/Personal Representative's name (typed/printed)

Notice: This petition must be filled out as fully as possible. The original must be sent to the Workers' Compensation Office of Adjudication, 1010 N. Seventh St, Suite 202, Harrisburg, PA, 17102-1400. You must serve a copy on all other parties, and on the attorneys of all other parties, if the attorneys are known. A Proof of Service must be attached. A Proof of Service is a signed statement signed by you verifying that you have sent a copy of the petition to all parties and their attorneys, if known. Questions regarding the completion of this form may be directed to the Bureau of Workers' Compensation Claims Information Services.

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
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
toll-free inside PA TTY: 800.362.4228
local & outside PA TTY: 717.772.4991

Email
ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program