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

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 # _____

INJURY INFORMATION

Description of injury or illness _____

_____

_____

_____

_____

Check if occupational disease ☐

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
PA Relay 7-1-1

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

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