

## DEATH CLAIM SUPPLEMENT TO COMPROMISE AND RELEASE AGREEMENT

Date of Injury: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY

PA BWC Claim Number: \_\_\_\_\_  
(IF KNOWN)

<b>Employee</b>		
First Name _____	Last Name _____	
Street 1 _____		
Street 2 _____		
City/Town _____	State _____	Zip Code _____
County _____	Telephone (____) _____ - _____	

<b>Employer</b>		
Name _____		
Street 1 _____		
Street 2 _____		
City/Town _____	State _____	Zip Code _____
County _____		
Telephone (____) _____ - _____	FEIN _____	

**TO THE PARTIES: THIS SUPPLEMENT MUST BE COMPLETED AND ATTACHED TO THE COMPROMISE AND RELEASE AGREEMENT FORM (LIBC 755) IN ALL CLAIMS ARISING OUT OF THE DEATH OF AN EMPLOYEE.**

**TO THE EXTENT THIS AGREEMENT REFERENCES AN INJURY FOR WHICH LIABILITY HAS NOT BEEN RECOGNIZED BY AGREEMENT OR BY ADJUDICATION, THE TERM "INJURY" AS USED IN THIS AGREEMENT SHALL MEAN "ALLEGED INJURY."**

**"FUND" SHALL MEAN THE UEGF, SIF, SIGF OR PRE-SIGF.**

**This form must be used as of February 1, 2011. Prior versions of the form will no longer be accepted.**

<b>Insurer, Fund or Third Party Administrator (if self-insured)</b>		
Name _____		
Street 1 _____		
Street 2 _____		
City/Town _____	State _____	Zip Code _____
County _____		
Telephone (____) _____ - _____	Bureau Code _____	
Insurer/TPA Claim Number _____	FEIN _____	

1. **Date of death:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY
  
2. Name and address of the widow or widower (include any maiden names, aliases and name upon remarriage, if applicable):
  
  
3. Names, addresses and dates of birth of all children:

4. If it is claimed that the dependency of any child continues beyond the age of eighteen (18) years, identify that child and state specifically the factual basis for this claim.

5. State the name, address and relationship to the employee of any other person claiming to be a dependent, (other than those individuals listed in items 2, 3 and 4 above) together with a brief summary of the factual basis for this claim.

6. Has a guardian been appointed for any child or dependent?  Yes  No  
If **Yes**, a copy of appointing Order must be attached.

All parties have read this agreement and agree to its contents.

Dated:      /      /       
          MM      DD      YYYY

\_\_\_\_\_  
WIDOW/WIDOWER/GUARDIAN SIGNATURE

\_\_\_\_\_  
WITNESS TO WIDOW/WIDOWER/GUARDIAN SIGNATURE

\_\_\_\_\_  
WIDOW/WIDOWER/GUARDIAN COUNSEL SIGNATURE

\_\_\_\_\_  
WITNESS TO WIDOW/WIDOWER/GUARDIAN SIGNATURE

\_\_\_\_\_  
FUND/EMPLOYER/INSURER/THIRD PARTY ADMINISTRATOR (SIGNATURE)

\_\_\_\_\_  
FUND/EMPLOYER/INSURER/THIRD PARTY ADMINISTRATOR COUNSEL (SIGNATURE)

\_\_\_\_\_  
If not witnessed above, this agreement must be notarized as follows:  
\_\_\_\_\_

**AFFIDAVIT/ACKNOWLEDGMENT:**

Before me, the undersigned Notary Public, in and for the aforesaid County and State, personally appeared \_\_\_\_\_ who being first duly sworn, does depose and state that he/she knows (or has satisfactorily proven to be) the individual identified as the employee in the foregoing compromise and release agreement; and that he/she has executed the foregoing compromise and release agreement for the purposes stated herein.

\_\_\_\_\_  
NOTARY PUBLIC

**THE COMPROMISE AND RELEASE AGREEMENT IS NOT VALID AND BINDING UNLESS APPROVED BY A WORKERS' COMPENSATION JUDGE IN A DECISION.**

Any individual filing misleading or incomplete information knowingly and with 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).

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