

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 - - by _____
MM DD YYYY 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 - - to - -
MM DD YYYY MM DD YYYY
Total amount paid was \$ _____ . ____ .

9. Dependents are as follows:

NAME	ADDRESS	DATE OF BIRTH	RELATIONSHIP	US CITIZEN	
		MM-DD-YYYY		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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