

## AGREEMENT FOR COMPENSATION FOR DEATH

DECEASED'S SOCIAL SECURITY NUMBER OR WC ID NUMBER

-  -

DATE OF INJURY

-  -

MM                  DD                  YYYY

WCAIS CLAIM NUMBER

### DECEASED EMPLOYEE

First name \_\_\_\_\_

Last name \_\_\_\_\_

Date of birth   -   -

MM                  DD                  YYYY

Date of death   -   -

MM                  DD                  YYYY

### EMPLOYER

Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_ ZIP \_\_\_\_\_

County \_\_\_\_\_

Telephone \_\_\_\_\_ FEIN \_\_\_\_\_

### DEPENDENT/GUARDIAN/PERSONAL REPRESENTATIVE

First name \_\_\_\_\_

Last name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_ ZIP \_\_\_\_\_

County \_\_\_\_\_ Telephone \_\_\_\_\_

### 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

Part of body injured \_\_\_\_\_

Nature of injury \_\_\_\_\_

Accident/injury description narrative \_\_\_\_\_

Check if occupational disease

NOTICE: Agreement should be clearly completed, (preferably typed) and uploaded in accordance with the provisions of EDI Implementation Guide. A copy must be sent to the dependent/guardian/personal representative. Wage information must be completed in accordance with Section 309 of the Pennsylvania Workers' Compensation Act, and sent to the Dependent/Guardian/Personal Representative.

We, the following persons, dependents of the aforementioned deceased employee, and the undersigned employer, agree upon the following matters which determine dependents' rights to compensation and its amount and duration.

Employer Representative's signature \_\_\_\_\_

NAME	RESIDENCE	DATE OF BIRTH MM-DD-YYYY	RELATIONSHIP
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Compensation was paid beginning   -   -     and ending   -   -     for the employee's disability prior to death.

The compensation payable under the agreed facts, based on the average weekly wage of \$ \_\_\_\_\_, is as follows:

WEEKLY RATE	FROM MM-DD-YYYY	THROUGH MM-DD-YYYY	#WEEKS/#DAYS	REASON FOR CHANGE	AMOUNT
\$ _____	_____	_____	_____	_____	\$ _____
\$ _____	_____	_____	_____	_____	\$ _____
\$ _____	_____	_____	_____	_____	\$ _____
\$ _____	_____	_____	_____	_____	\$ _____
\$ _____	_____	_____	_____	_____	\$ _____
\$ _____	_____	_____	_____	_____	\$ _____
\$ _____	_____	_____	_____	_____	\$ _____

Amount expended for medical \$ \_\_\_\_\_ Amount expended for burial \$ \_\_\_\_\_

Further matters agreed upon:

Date of agreement  
  -   -      
 MM DD YYYY

\_\_\_\_\_  
 Dependent/Guardian/Personal Representative's signature

\_\_\_\_\_  
 Claims Representative's name (typed/printed)

\_\_\_\_\_  
 Claims Representative's signature

\_\_\_\_\_  
 Telephone

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*