pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

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.

NAME	RESIDENCE	DATE OF BIRTH MM-DD-YYYY	RELATIONSHIP

Compensation was paid beginning ☐☐ - ☐☐ - ☐☐☐☐ and ending ☐☐ - ☐☐ - ☐☐☐☐ for the employee's disability prior to death
MM DD YYYY MM DD YYYY

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:

____
Dependent/Guardian/Personal Representative's signature

____
Employer Representative signature

____
Claim Representative name (printed or typed)

____
Claim Representative signature

____
Claim Representative telephone number

____
Date of agreement

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