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)

## DEPENDENT/GUARDIAN/PERSONAL REPRESENTATIVE

First name ________________
Last name ________________
Address ________________
Address ________________
City/Town ________ State ___ ZIP ______
County ________ Telephone ________

## INJURY INFORMATION

Part of body injured ________________
Nature of injury ________________

Accident/injury description narrative ________________

Check if occupational disease ☐

## 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 # ________________

**NOTICE:** Agreement should be clearly completed, preferably typed, and uploaded in accordance with the provisions of the 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 $ ________________________

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Further matters agreed upon:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________
Dependent/Guardian/Personal Representative's signature

Date of agreement
[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
MM DD YYYY

______________________________________________
Employer/Insurer Representative's name (typed/printed)

______________________________________________
Employer/Insurer Representative's signature

______________________________________________
Employer/Insurer Representative's telephone number

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