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