

SUPPLEMENTAL 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 employee. 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, are parties to a compensation agreement or award which is changed because on

- -

MM DD YYYY

the dependent, _____

Died Remarried A posthumous child was born Other _____

