

WORKERS' COMPENSATION APPEALS BOARD

APPLICATION FOR ADJUDICATION OF CLAIM (Death Case)
(PRINT OR TYPE NAMES AND ADDRESSES)

CASE No. _____

M _____
(APPLICANT)

(APPLICANT'S ADDRESS AND ZIP CODE)

(DECEASED EMPLOYEE)

Social Security No _____

(EMPLOYER--STATE IF SELF-INSURED)

(EMPLOYER'S ADDRESS AND ZIP CODE)

(EMPLOYER'S INSURANCE CARRIER OR, IF SELF-INSURED, ADJUSTING AGENCY)

(INSURANCE CARRIER OR ADJUSTING AGENCY'S ADDRESS)

IT IS CLAIMED THAT:

1. Deceased employee, born _____, while employed as a _____
(DATE OF BIRTH) (OCCUPATION AT TIME OF INJURY)
on _____, at _____, by the employer sustained
(DATE OF INJURY) (ADDRESS) (CITY) (STATE) (ZIP CODE)
injury arising out of and in the course of employment to _____
(STATE WHAT PARTS OF BODY WERE INJURED)

2. The injury occurred as follows _____
(EXPLAIN WHAT EMPLOYEE WAS DOING AT TIME OF INJURY AND HOW INJURY WAS RECEIVED)
_____ resulting in death on _____
(DATE OF DEATH)

3. Actual earnings at time of injury were: _____
(GIVE WEEKLY OR MONTHLY SALARY OR HOURLY RATE AND NUMBER OF HOURS WORKED PER WEEK)

4. The injury caused disability as follows: _____
(SPECIFY LAST DAY OFF WORK DUE TO THIS INJURY AND BEGINNING AND ENDING DATES OF ALL PERIODS OFF DUE TO THIS INJURY)

5 Compensation was paid _____ \$ _____ \$ _____
(YES) (NO) (TOTAL PAID) (WEEKLY RATE) (DATE OF LAST PAYMENT)

6. Medical treatment was received _____ All treatment was furnished by the employer or
(YES) (NO) (DATE OF LAST TREATMENT)
insurance company _____ other treatment was provided or paid for by _____
(YES) (NO) (NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)

Did Medi-Cal pay for any health care related to this claim _____ Doctors not provided or paid for by employer or
(YES) (NO)
insurance company, who treated or examined for this injury are: _____
(STATE NAMES AND ADDRESSES OF SUCH DOCTORS AND NAMES OF HOSPITALS TO WHICH SUCH DOCTORS ADMITTED INJURED)

7. Defendants have paid burial expense _____ TOTAL PAID _____
(YES) (NO)

8. The employee left surviving the following dependents:

NAME	DATE OF BIRTH (if under 18)	RELATIONSHIP TO THE EMPLOYEE	ADDRESS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

WHEREFORE, applicant requests a hearing and an award of: Death benefit _____ Burial expense _____ Compensation
accrued and unpaid _____ Unpaid medical bills _____ Other (specify) _____
_____ and all other appropriate benefits provided by law.

Dated at _____, California, _____
(CITY) (DATE)

(APPLICANT'S ATTORNEY)

(APPLICANT'S ATTORNEY'S ADDRESS)

(APPLICANT'S SIGNATURE)