COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 S. CAMERON STREET, ROOM 103
HARRISBURG, PA 17104-2501
(TOLL FREE) 800-482-2383
TTY 800-362-4228

FATAL CLAIM PETITION FOR COMPENSATION BY DEPENDENTS OF DECEASED EMPLOYEES

Deceased's
Social Security Number: _____ - _____ - _____

Date of Injury: _____/_____/_____
MM DD YYYY

PA BWC Claim Number: _____
(IF KNOWN)

Deceased Employee

First Name _____ Last Name _____

Date of Birth _____/_____/_____ (MM DD YYYY) Date of Death _____/_____/_____ (MM DD YYYY)

Dependent

First Name _____ Last Name _____

Street 1 _____

Street 2 _____

City/Town _____ State _____ Zip Code _____-_____

County _____ Telephone (_____) _____-_____

Injury

Description of Injury and Cause of Death

_____

_____

_____

_____

_____ Check if Occupational Disease ☐

VS.

Employer

Name _____

Street 1 _____

Street 2 _____

City/Town _____ State _____ Zip Code _____-_____

County _____

Telephone (_____) _____-_____ FEIN _____

Insurer or Third Party Administrator (if self-insured)

Name _____

Street 1 _____

Street 2 _____

City/Town _____ State _____ Zip Code _____-_____

Telephone (_____) _____-_____ Bureau Code _____

County _____

Claim Number _____ FEIN _____

The petitioner respectfully alleges that:

1. Business of employer _____
2. Time of injury (hour) _____ ☐ AM ☐ PM
3. The cause of death was _____ as given by _____

   _____

4. The deceased employee received aid from the following doctors and/or hospitals:

   _____

   GIVE NAMES AND ADDRESSES. IF NONE, SO STATE.

5. Expenses of the last illness and burial amounted to $_____._____

   Amount paid by employer $_____._____

6. The wages of deceased at the time of accident were $_____._____ ☐ hour ☐ day ☐ week

NOTICE: Petition should be clearly completed (preferably typed) and original mailed to the Bureau at the address in the upper left corner.

(OVER)

7. Notice of injury and/or death was given to employer on ____/____/_____ by _____
MM DD YYYY NAME OF PERSON REPORTING INJURY/DEATH

in the following manner _____
STATE WHEN AND TO WHOM NOTICE WAS GIVEN AND IN WHAT MANNER.

8. Compensation for disability was paid to the deceased employee from ____/____/_____ to ____/____/_____.
MM DD YYYY MM DD YYYY

Total amount paid was $_____._____

9. Dependents are as follows:

NAME	RESIDENCE	DATE OF BIRTH (MM/DD/YYYY)	RELATIONSHIP
		____/____/____	
		____/____/____	
		____/____/____	
		____/____/____	
		____/____/____	

10. Their dependency is ☐ Total ☐ Partial

11. Petitioner ☐ was ☐ was not living with the deceased at the time of his or her death.

12. The petitioner ☐ is ☐ is not a widow/widower of the deceased.

a. If petitioner is a widow or widower, state where ceremony was performed and give date of marriage.

_____ ____/____/____
MM DD YYYY

b. Was marriage a common law marriage? ☐ Yes ☐ No

13. Other facts which I believe to be important are _____

_____

WHEREFORE, the Petitioner(s) asks that the Bureau shall make an award in accordance with the Pennsylvania Workers' Compensation Act.

DATE OF THIS NOTICE: ____/____/_____
MM DD YYYY

A copy of this petition has been sent to the defendant.

Signature

_____

Dependent

First Name _____ Last Name _____

Signature _____

PLEASE ENTER MY APPEARANCE FOR PETITIONER:
Attorney

Name _____

Firm Name _____

Street 1 _____

Street 2 _____

City/Town _____ State _____ Zip Code _____-_____

Telephone (_____) _____-_____ PA Attorney ID Number _____

Any individual filing misleading or incomplete information knowingly and with intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties through Pennsylvania Act 165 of 1994.

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program