PETITION TO DETERMINE COMPENSATION DUE TO DEPENDENTS OF DECEASED EMPLOYEE

_____

To the Industrial Accident Board of the State of Delaware

Sitting in and for _____ County

_____
Claimant (Deceased Employee)

vs.

_____
Employer

}

Claimant SS# _____

Date of Birth _____

Insurance Carrier _____

OWC Case File No. _____

The undersigned petitioner respectfully represents:

That the above named claimant and the above named employer have failed to reach an agreement in regards to compensation due to the dependent of _____ _____a deceased employee of said employer.

The undersigned therefore prays that your Honorable Board shall, after due notice of the time and place of hearing served on all parties in interest, hear and determine the matter in accordance with the facts and the law and state its conclusions of fact and rulings of law.

Dated this _____day of _____ 20

Witness:

_____
Signature

_____
Print Name

Name:

_____
Signature

_____
Print Name

INDUSTRIAL ACCIDENT BOARD
STATE OF DELAWARE

Statement of Facts Upon Failure to Reach an Agreement

1. Name of Employee _____

   Address _____

   City _____ State _____ Zip _____

   Telephone Number _____ E-mail (optional) _____

2. Date of Accident _____ 3. Place of Accident _____

4. Name of Employer _____

   Employer Contact Name _____ E-mail (optional) _____

   Address _____

   City _____ State _____ Zip _____

   Telephone Number _____ Fax# _____

5. Name of lnsurance Carrier/ 3rd Party Administrator _____

6. Occupation of employee at the time of accident _____

7. Nature of accident and how it happened _____

_____

8. Describe the nature of injury _____

_____

9. Did employee receive medical, surgical or hospital service? Yes _____ No _____

10. When was notice of injury given to or received by employer? _____

11. Give names and addresses of all employers for the last 5 years. If more space is needed, attach a separate sheet.

NAME:	ADDRESS:

12. State weekly wage when injured _____

13. State names and addresses of all treating doctors for this claim. If more space is needed, attach a separate sheet.

NAME:	ADDRESS:

14. State number of weeks employed during the last twelve months _____

15. State at what trade or occupation employed during the last twelve months _____

_____

16. Date of death _____

17. What were the expenses of last sickness and burial _____

_____

18. Amount of these expenses paid by the employer _____

_____

19. Name of widow or widower of deceased, if dependent _____

_____

20. Names and dates of birth of dependent children under sixteen years of age.

_____ _____

_____ _____

_____ _____

_____ _____

21. Names and addresses of surviving father and mother of deceased, if dependent.

_____ _____

22. Give names and dates of birth of dependent sibling(s) of deceased under sixteen years of age.

_____ _____

_____ _____

23. State any other important facts bearing on the case above presented.

_____

_____

_____

I swear or affirm that the information contained in this statement is true and correct to the best of my knowledge and recollection. I understand and acknowledge that any falsehood contained in this statement may expose me to civil or criminal liability.

Dated: ___ Day of_____, YEAR

_____

Dependent Signature