STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS

SEE REVERSE SIDE FOR INSTRUCTIONS

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 _____ (DATE OF BIRTH) while as employed as a _____ (OCCUPATION AT TIME OF INJURY)

   on _____ (DATE OF INJURY), at _____ (ADDRESS) (CITY) (STATE) (ZIP CODE), by the employer sustained 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 ☐ (YES) ☐ (NO) _____ (DATE OF LAST TREATMENT). All treatment was furnished by the employer or insurance company ☐ (YES) ☐ (NO) other treatment was provided or paid by _____ (NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CLAIM)

   Did Medi-Cal pay for any health care related to this claim _____ (YES) _____ (NO) Doctors not provided or paid for by employer or 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 ☐ (YES) ☐ (NO) TOTAL PAID _____

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 _____ (CITY), California, _____ (DATE)

_____
(APPLICANT'S ATTORNEY)

_____
(ADDRESS AND TELEPHONE NUMBER OF ATTORNEY)

_____
(APPLICANT'S SIGNATURE)

INSTRUCTIONS

FILING AND SERVICE OF A DECLARATION OF READINESS (DWC Form 10250.1)
IS PREREQUISITE TO THE SETTING OF A CASE FOR HEARING.

Effect of Filing Application

Filing of this application begins formal proceedings against the defendants named in your application.

Assistance in Filling out Application

You may request the assistance of an information and assistance officer of the Division of Workers' Compensation.

Right to Attorney

You may be represented by an attorney or agent, or you may represent yourself. The attorney fee will be set by DWC judge at the time the case is decided and is ordinarily payable out of your award.

Filling Out Application

All blanks in the application shall be completed. Where the information is unknown, place "unknown" in the blank. If medical treatment is paid for by Medi-Cal, Medicare, group health insurance or private carrier, please specify.

Service of Documents

Your attorney or agent will serve all documents in accord with Labor Code Section 5501 and Section 10500 of the Workers' Compensation Appeals Board's Rules of Practice and Procedure.

If you have no attorney or agent, copies of this application will be served by the Division of Workers' Compensation on all parties. If you file any other document, you must mail or deliver a copy of the document to all parties in the case.

IMPORTANT!

If any applicant is under 18 years of age, it will be necessary to file Petition for Appointment of Guardian ad Litem.