

**DISTRICT OF COLUMBIA GOVERNMENT
DEPARTMENT OF EMPLOYMENT SERVICES
OFFICE OF WORKERS' COMPENSATION**

**P.O. BOX 56098
WASHINGTON, D.C. 20011**

(202) 671-1000

NOTICE OF CLAIM FOR DEATH BENEFITS

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

To preserve compensation rights under the law, this notice should be completed and signed by the dependents of the deceased who are making claim, or by someone who is making claim on their behalf. Within 30 days after death, this form should be mailed or delivered - the original to the address given below and a copy to the employer.

Name of Deceased Employee (First, middle initial, last)		Date of Death
Last Address of Deceased (Number, Street, City & State)		Date of Injury
Name of Employer of Deceased Employee	Address (Number, St., City, State)	
Place or location where injury occurred (Nearest street Address)		
Place of death, if other than above location		
Nature of injury or occupational disease and cause of death		
Name of last physician or hospital		Address of last physician or hospital (Number, St., City and State)
CHECK BOX(ES)	<input type="checkbox"/> I am giving notice and making claim for compensation for self. <input type="checkbox"/> I am giving notice and making claim for compensation on behalf of the following dependents (children under 18, widow, etc.)	
Name of Dependent	Date of Birth	Relationship
ADDRESS		
UPON CONTACT BY THE EMPLOYER OR THEIR INSURANCE CARRIER, PLEASE PROVIDE THEM COPIES OF BIRTH CERTIFICATES OF DEPENDENT CHILDREN, MARRIAGE CERTIFICATE OR OTHER DOCUMENTS OF PROOF OF DEPENDENCE.		
Signature of Person Completing this Form		Address (No., St., City & State)
Relationship to Deceased		Date of this Notice (mo-day-yr)
BE SURE TO SEND ONE COPY OF THIS FORM TO EMPLOYER		
MAIL OR DELIVER THE ORIGINAL OF THIS NOTICE TO	→	Office of Workers' Compensation P.O. Box 56098 Washington, D.C. 20011, and copy to your employer.