

**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)	}	Claimant SS# _____
vs.		Date of Birth _____
Employer		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:

Name:

Signature

Signature

Print Name

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 Insurance 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.

_____	_____
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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