pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

AGREEMENT FOR COMPENSATION FOR DEATH

DECEASED'S SOCIAL SECURITY NUMBER OR WC ID NUMBER

DATE OF INJURY (MM - DD - YYYY)

WCAIS CLAIM NUMBER

DECEASED EMPLOYEE

First name _____

Last name _____

Date of birth ___ - ___ - ____ (MM DD YYYY)

Date of death ___ - ___ - ____ (MM DD YYYY)

DEPENDENT/GUARDIAN/PERSONAL REPRESENTATIVE

First name _____

Last name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____ Telephone _____

INJURY INFORMATION

Part of body injured _____

Nature of injury

Accident/injury description narrative

Check if occupational disease

EMPLOYER

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

Contact _____

NAIC code _____ or Insurer code _____

Insurer/TPA claim # _____

NOTICE: Agreement should be clearly completed, (preferably typed) and uploaded in accordance with the provisions of EDI Implementation Guide. A copy must be sent to the dependent/guardian/personal representative. Wage information must be completed in accordance with Section 309 of the Pennsylvania Workers' Compensation Act, and sent to the Dependent/Guardian/Personal Representative.

We, the following persons, dependents of the aforementioned deceased employee, and the undersigned employer, agree upon the following matters which determine dependents' rights to compensation and its amount and duration.

NAME	RESIDENCE	DATE OF BIRTH MM-DD-YYYY	RELATIONSHIP

Compensation was paid beginning ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY) and ending ☐☐ - ☐☐ - ☐☐☐☐ (MM - DD - YYYY) for the employee's disability prior to death.

The compensation payable under the agreed facts, based on the average weekly wage of $ _____ , is as follows:

WEEKLY RATE	FROM MM-DD-YYYY	THROUGH MM-DD-YYYY	#WEEKS/#DAYS	REASON FOR CHANGE	AMOUNT
$					$
$					$
$					$
$					$
$					$
$					$
$					$

Amount expended for medical $ _____ Amount expended for burial $ _____

Further matters agreed upon:

Dependent/Guardian/Personal Representative's signature

Employer Representative signature

Claim Representative name (printed or typed)

Claim Representative signature

Claim Representative telephone number

Date of agreement

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
PA Relay 7-1-1

Email
ra-li-bwc-helpline@pa.gov

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