Fatal Award Agreement

Virginia Workers' Compensation Commission
333 E. Franklin St., Richmond, Virginia 23219
1-877-664-2566

SEE INSTRUCTIONS ON REVERSE SIDE

www.workcomp.virginia.gov

Jurisdiction Claim #: _____

Claim Administrator #: _____

Injured Worker's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: ( ) -

Employer's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer's Phone: _____

Date of Injury: _____ **Pre-Injury Average Weekly Wage:** _____

Agreement entered into this _____ day of _____, 20_____ by and between the Employer/Claim Administrator and Statutory Dependent(s) for compensation due the dependent(s) of the Employee who sustained an injury on the _____ day of _____, 20_____ as a result of an accident arising out of and in the course of his/her employment which resulted in death on the _____ day of _____, 20_____.

The Employer/Claim Administrator agrees to pay and the Statutory Dependent(s) agrees to accept compensation for the benefit of the named dependent(s), in equal proportions, at the rate of $ _____ per week, payable every _____ week(s), unless subsequent conditions require a modification; all costs of necessary medical, surgical, and hospital attention and supplies incident to the injury (if any); actual burial expenses not to exceed $10,000.00; and incidental transportation expenses not to exceed $1,000.00.

Name	Address	Date of Birth	Relationship to Deceased

THIS AGREEMENT IS SUBJECT TO VERIFICATION AND APPROVAL BY THE COMMISSION

Signatures

By signing below, we certify that the facts relating to this accident are correct as presented on this form and agree that the dependent(s) shall receive the benefits indicated until suspended in accordance with the provisions of the Virginia Workers' Compensation Act.

Signature of Statutory Dependent _____ Print Name _____ Date (m/d/yyyy) _____

Signature of Claim Administrator _____ Print Name _____ Date (m/d/yyyy) _____

Print Name and Address of Claim Administrator _____ Phone Number _____

Print Name and Address of Deceased Worker's Attorney _____ Phone Number _____

Fatal Award Agreement
VWC Form #35

Filing Instructions

1. This form is used in cases that involve a compensable fatality to a worker with dependents. The Fatal Award Agreement provides information relating to the deceased workers' weekly wage and compensation rate, as well as the identity of dependent(s) entitled to receive compensation benefits pursuant to the Virginia Workers' Compensation Act. This Fatal Award Agreement, when executed, must be filed promptly with the Virginia Workers' Compensation Commission, 333 E. Franklin St., Richmond, Virginia 23219, by the Employer, Claim Administrator, or authorized representative.

2. This form must be accompanied by:

    - Death Certificate
    - Marriage License
    - Birth Certificate

3. For questions or assistance with completing this form, please contact Customer Assistance using the Commission's toll-free number 1-877-664-2566.