W.C.C. # of pending cases: _____

_____

State of Rhode Island and Providence Plantations

Providence, SC. Workers' Compensation Court

Petition For Compensation Benefits of Deceased Employee

1	NAME OF PETITONER	Social Security Number XXX – XX – (last 4 digits only)	7. NAME OF EMPLOYER OF DECEASED EMPLOYEE (Respondent)
2.	RELATIONSHIP OF PETITIONER TO DECEASED EMPLOYEE		8. BUSINESS ADDRESS (Street, No., City or Town, State and Zip Code)
3.	PETITIONER'S ADDRESS (Street, No., City or Town, State and Zip Code)		9. NAME AND ADDRESS OF AGENT FOR SERVICE OF PROCESS
4.	NAME OF DECEASED EMPLOYEE	Social Security Number XXX – XX – (last 4 digits only)	10. NAME OF EMPLOYER'S INSURANCE CARRIER ON DATE OF ALLEGED INJURY
5.	DATE AND PLACE OF DEATH OF EMPLOYEE		11. NATURE OF EMPLOYER'S BUSINESS
6.	DATE OF ALLEGED INJURY (Month, Day, Year, Time)		12. DID INJURY OCCUR ON EMPLOYER'S PREMISES? ☐ Yes ☐ No IF NOT, WHERE DID INJURY OCCUR?

13. NAME(S) AND ADDRESS(ES) OF WITNESS(ES) TO INJURY

14. HOW DID INJURY OCCUR?

15. NATURE AND EXTENT OF INJURY

16. NAME(S) OF PHYSICIAN(S) AND HOSPITAL(S) WHO RENDERED SERVICES

17. WEEKLY WAGES AT TIME OF INJURY	18. FIRST DAY OF LOST TIME FROM WORK

19 NAME AND TITLE OF PERSON IN EMPLOY OF EMPLOYER, WHO WAS NOTIFIED OR WHO HAD KNOWLEDGE OF INJURY TO DECEASED

20. DID DECEASED EMPLOYEE RECEIVE WORKERS' COMPENSATION BENEFITS FOR THE ABOVE INJURY?
UNDER A NON-PREDJUDICIAL AGREEMENT? ☐ Yes ☐ No UNDER A MEMORANDUM OF AGREEMENT? ☐ Yes ☐ No

UNDER A DECREE OF THE WORKERS' COMPENSATION COURT? ☐ Yes ☐ No

21, WAS AN ESTATE OPENED? ☐ Yes ☐ No IF SO WHERE? NAME OF ADMINISTRATOR(S) OR EXECUTOR(S)

22. NAME OF PERSON PAYING BURIAL EXPENSES, AND AMOUNT PAID

NAME, ADDRESS, RELATIONSHIP, AND DATES OF BIRTH OF ALL DEPENDENTS OF DECEASED EMPLOYEE WHO WERE DEPENDENT AT THE TIME OF INJURY OR DEATH.

NAME	ADDRESS	RELATIONSHIP TO DECEASED EMPLOYEE	DATE OF BIRTH OF MINORS

CHECK THE BENEFITS YOU ARE SEEKING:

☐ WEEKLY BENEFITS PURSUANT TO R.I.G.L. §§ 28-33-12 AND 28-33-23

☐ FUNERAL EXPENSES PURSUANT TO R.I.G.L. § 28-33-16

☐ OTHER, PLEASE SPECIFY

I hereby petition that my rights to benefits under the Workers' Compensation Act may be determined, and in support of this pleading I make the foregoing statements of fact: that both said employer and deceased employee were subject to the provisions of the Workers' Compensation Act; that said employee's injury was not occasioned by the employee's willful intention to bring about the injury or death of himself/herself or another; and that said injury did not result from the employee's intoxication on duty or unlawful use of controlled substances. I have attached a duly certified copy of the certificate of death along with any agreement or decree to pay workers' compensation benefits, if applicable.

Attorney Name	Signature of Petitioner
Attorney Address and Phone Number	Print Name of Petitioner
Attorney Bar Registration Number	Date

File the original and three copies with the appropriate attachments with the Office of the Administrator of the Workers' Compensation Court, J. Joseph Garrahy Judicial Complex, One Dorrance Plaza, Providence, Rhode Island 02903-3973.

Distribution: White: Original Yellow: Agent for Service of Process/Employer Pink: Dependent/Attorney Gold: Insurance Carrier

Rev 02/08