GOVERNMENT OF
THE VIRGIN ISLANDS OF THE UNITED STATES
◆
DEPARTMENT OF LABOR

4401 Sion Farm - Christiansted
St. Croix, VI 00820-4245
Phone: (340) 713-3413
Fax: (340) 772-3365

P. O. Box 302608
St. Thomas, VI 00803
Phone: (340) 776-3700
Fax: (340) 774-6801

Workers' Compensation Administration

CLAIM FOR COMPENSATION ON ACCOUNT OF DEATH

INSTRUCTIONS: Every question on this blank must be answered. Write in ink or on a typewriter. The claim must be filed within 60 days after the injury or death. Be sure to give the name and address of the employer.
(THIS CLAIM MUST BE SWORN TO IN THE PRESENCE OF A NOTARY PUBLIC)

I hereby make claim for compensation for an injury resulting in death of ______________________________ due to an accident which occurred on the ______ day of ______ ______________________ 20 ____, sustained while in the performance of duty in the employment of ______________________________ of ______________________________

Name of Employer *Address of Employer*

Full name of deceased ______________________________

Nature and extent of injury ______________________________

____

Date of death ______________________ Place where death occurred ______________________

Rate of pay of deceased employee at time of injury which resulted in death ______________________

$ ______________ per week; $ ______________ per day; $ ______________ per hour, and substance valued: $ ______________

With reference to above claim, I hereby make the following statements:

REGARDING THE DECEASED EMPLOYEE: Sex? ____ Age? ____ Usual Occupation ______________

Did deceased speak English? ______ If not, what language? ______________ Married or single? ______________

Where born? ______________ How long did deceased work for the employer indicated above? ______________

In what occupation? ______________ Was deceased doing usual work when injured? ______ If not, what work? ______________________________

REGARDING PLACE OF ACCIDENT: Location where accident occurred ______________________________ If away from employer's premises, give brief explanation of duty which carried deceased there ______________________________

REGARDING MEDICAL ATTENDANCE: Did you or deceased or anyone for him request employer to provide medical attendance? ________ Has he done so? ________ What physician attended deceased? ______________________________ Where? ______________________________

Was deceased sent to hospital? ________ What hospital? ______________________________

REGARDING SURVIVING SPOUSE: Full name of surviving spouse ______________________________

Date of birth ____________ Place of birth ______________________ Address ______________________

Date of marriage to deceased employee ______________________ Place of marriage ______________________

Number of children of said marriage now living ____________ Indicate by number those children on list below who are of said marriage ________ Information as to dependency of spouse on deceased employee ______________

____

REGARDING SURVIVING CHILDREN: Full names, sex, and dates of birth of children under 18 years of age at the time of death of deceased employee, or who, though over 18 years of age, are disabled for work or otherwise unable to support themselves:

Name	Sex	Date of Birth	Address	Information as to dependency on deceased employee
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Name and address of surviving parent (not a spouse of the deceased) of any children listed above. (Indicate children of which survivor is parent) ______________________________

____

REGARDING OTHER DEPENDENTS:

Name	Sex	Date of Birth	Relationship to Deceased	Address	Information as to dependency on deceased employee
1.					
2.					
3.					
4.					
5.					

REGARDING GUARDIANS: Names and address of guardian of each minor listed in this claim:

Name of Minor	Name of Guardian	Address	Relationship to minor, if any
1.			
2.			
3.			

I hereby certify that each and every statement set forth above is true to the best of my knowledge and belief.

ACKNOWLEDGE, SUBSCRIBED AND SWORN TO BEFORE ME THIS _______ DAY OF ________________ 20 ______ , AD

____
Signature of Person filing claim on behalf of dependents of deceased employee

____
Relationship to deceased employee, if any

____
Notary Public

____
Address