GOVERNMENT OF
THE VIRGIN ISLANDS OF THE UNITED STATES

DEPARTMENT OF LABOR

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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 the death of _____

due to an accident that 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 the death occurred _____

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

$_____ per week; $ _____ per day; $ _____ per hour, and

substance valued: $ _____

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

REGARDING THE DECEASED EMPLOYEE: Sex? ____ Age?_____ Usual Occupation _____
Did the deceased speak English? _____ If not, what language?_____ Married or single? _____

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

In what occupation?_____Was the deceased doing usual work when injured? _____ If not, what

work? _____

REGARDING PLACE OF ACCIDENT: Location where the accident occurred _____

_____ If away from employer's premises, give a brief explanation of duty

which carried deceased there _____

REGARDING MEDICAL ATTENDANCE: Did you or the deceased or anyone for him request the employer to

provide medical attendance? _____ Has he done so? _____ What physician attended deceased? _____

_____ Where? _____

Was the deceased sent to the 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 the list

below who are of said marriage _____ Information as to dependency of spouse on the 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 the 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 the 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