SAVE PRINT CLEAR

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

FORWARD TO

P.O. BOX 422400
SAN FRANCISCO CA 94142

NOTICE OF EMPLOYEE DEATH

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EACH EMPLOYER SHALL NOTIFY THE ADMINISTRATIVE DIRECTOR OF THE DEATH OF EVERY EMPLOYEE REGARDLESS OF THE CAUSE OF DEATH EXCEPT WHERE THE EMPLOYER HAS ACTUAL KNOWLEDGE OR NOTICE THAT THE DECEASED EMPLOYEE LEFT A SURVIVING MINOR CHILD (TITLE 8, CHAPTER 4.5, SECTION 9900).

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DECEASED EMPLOYEE:

NAME: _____ AGE: _____ SOCIAL SECURITY NUMBER: _____

LAST KNOWN ADDRESS: _____

NAME, RELATIONSHIP AND LAST KNOWN ADDRESS OF NEXT OF KIN: _____

_____

JOB TITLE AND NATURE OF DUTIES: _____

_____

DATE, TIME AND PLACE OF ACCIDENT: _____

DATE, TIME AND PLACE OF DEATH: _____

CIRCUMSTANCES OF DEATH (DESCRIBE FULLY THE EVENTS WHICH RESULTED IN DEATH. TELL WHAT HAPPENED. USE ADDITIONAL SHEET IF NECESSARY):

_____

CAUSE OF DEATH (ATTACH COPY OF DEATH CERTIFICATE OR CORONER'S REPORT):

_____

HAVE ANY WORKERS' COMPENSATION DEATH BENEFITS BEEN PROVIDED IN CONNECTION WITH THIS DEATH? ____ YES ____ NO

IF YES, TO WHOM: _____

ATTACH A COPY OF THE FORM 5020, "EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS," IF ONE WAS FILED.

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PLEASE NOTE:

IF THE DEATH IS WORK-RELATED, THE EMPLOYER ALSO IS REQUIRED TO REPORT THE DEATH TO HIS OR HER WORKERS' COMPENSATION INSURANCE CARRIER AND TO THE NEAREST OFFICE OF THE DIVISION OF INDUSTRIAL SAFETY IMMEDIATELY BY TELEPHONE OR TELEGRAPH. AN EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS SHOULD ALSO BE FILED WITH THE WORKERS' COMPENSATION INSURANCE CARRIER.

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( ) INSURED ( ) SELF-INSURED ( ) LEGALLY UNINSURED

EMPLOYER: _____

STREET: _____

CITY/STATE: _____ ZIP: _____

TELEPHONE: _____
(INCLUDE AREA CODE)

INSURANCE CARRIER
OR ADJUSTING AGENT: _____

STREET: _____

CITY/STATE: _____ ZIP: _____

TELEPHONE: _____
(INCLUDE AREA CODE)

BY:_____

TITLE: _____

DATE: ----------

DIA 510 (REV. 9/84)