Ohio | Bureau of Workers' Compensation

Application for Adjustment of Claim in Case of Death Due to Occupational Disease

Instructions: You must file this form in duplicate and have it accompanied by duplicate copies of the proof relied upon to support the claim.

O.D. _____
(BWC Claim Number)

Employer: _____ _____
(Employer Address)

Employee: _____ Beneficiary: _____
(Deceased)

The above named _____
(Employer or Beneficiary)

hereby gives notice to the Ohio Bureau of Workers' Compensation (BWC) that the parties hereto have failed to reach an agreement in regard to compensation, etc., to be paid on account of the death of the above named employee; and hereby makes application to BWC for the purpose of determining the amount of compensation, etc., to be paid or furnished to said beneficiary, or beneficiaries, in accordance with the provisions of Section 27 of the Workers' Compensation Act.

The reasons for disagreement are as follows: _____

_____

_____

_____

_____

_____

_____

Said applicant, in support of said application, submits the following statement of facts for the consideration of BWC:

1. What was deceased's age? _____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced
2. From what disease was deceased suffering? _____
3. What were the symptoms? _____
4. When did these symptoms first appear? _____
5. Had deceased previously suffered from this disease? _____
6. On what day did deceased quit work on account of the disease? _____
7. Give date of death _____ Hour of day _____ ☐ AM ☐ PM
8. Name of Attending Physician _____ Address _____
9. When did deceased last become a resident of Ohio? _____
10. Was autopsy performed? . . . ☐ Yes ☐ No By whom? _____
11. Give the name and address of the employer or employers for whom deceased worked for ninety days preceding date of death.

    _____

    _____
12. This application is made on behalf of the above named beneficiary and the following named persons, who were dependent on deceased for support:

Name	Age	Relationship to deceased	Wholly or partially

13. The expenses below have been incurred for medical and funeral expenses, etc., in connection with the disability and death of said employee:

Nature of expense	Amount	Nature of expense	Amount
Medical services:	_____	Nursing services:	_____
Hospital services:	_____	Funeral:	_____

By signing this application I expressly waive, on behalf of myself and of any person who shall have any interest in this claim, all provisions of law forbidding any physician or other person who has heretofore attended or examined deceased from disclosing any knowledge or information which they thereby acquired.

I have read all the statements contained herein and know the same to be true and correct.

Signed _____
(Applicant)

_____
(Address)

Dated at _____ this _____ day of _____ , _____ .