WORKER'S COMPENSATION COMMISSION

Department of Labor * Government of Guam
P.O. Box 9970 * Tamuning, Guam 96931
Tel: (671) 300-4571/77 * Fax: (671) 475-6811

WCC File #:

INSTRUCTIONS: Use this form to claim for death benefits for WIDOW, WIDOWER, and/or DEPENDENT CHILDREN under the Worker's Compensation Law. Submit claim (in duplicate) to the Office of the Worker's Compensation Commission. FILE WITHIN ONE (1) YEAR of the death of employee, or after it was concluded that death was related to the employment. A person other than the widow, widower, and/or child may complete claim for the beneficiary.

**** NO CLAIM FOR DEATH BENEFIT NEED BE PAID UNLESS A COMPLETED CLAIM FORM HAS BEEN FILED ****

1. Deceased Employee's Name & Address:	2. Employer's Name & Address: EIN #:
3. Date of injury:	4. Place of injury/death:
5. Date of death:	6. Nature/cause of injury/death:

7. CLAIM FOR WIDOW/WIDOWER

a. Name:	b. Date of birth:	c. Citizenship:	d. SSN:
e. Date of marriage to Decedent:	f. Place of marriage:		

8. CLAIM FOR UNMARRIED CHILDREN UNDER THE AGE OF EIGHTEEN

**** Ethnicity such as: Yapese, Chuukese, Kosraean, Pohnpeian, Marshallese, Palauan, American, African American, Chamorro, Filipino, Korean, Chinese, Japanese, Other (please specify)**

a. NAME	b. DATE OF BIRTH	c. CITIZENSHIP	d. ETHNICITY** (Please choose from above examples)	e. SSN
(1)				
(2)				
(3)				
(4)				
(5)				

9. Name and Address of last Physician:	10. Name and Address of Undertaker:

11. Cost of Burial/Funeral:	12. Amount paid:	13. Name of person paying bill:

14. Name and Signature of person completing claim:	15. Address of person completing claim:
16. Date of this claim:	