



**NON-DEPENDENT(S)
REPORT OF DEATH**
CLAIMS DIVISION
SFN 10013 (01/2015)

1600 E Century Ave, Ste 1
PO Box 5585
Bismarck ND 58506-5585
Telephone 800-777-5033
Toll Free Fax 888-786-8695
TTY (hearing impaired) 800-366-6888
Fraud and Safety Hotline 800-243-3331
www.workforcesafety.com

Please print or type using black or blue ink and return to WSI. This form should be completed by surviving non-dependent relatives of a deceased employee when there is no surviving spouse or dependent child(ren). Application for death benefits in all cases of injury resulting in death must be made by the beneficiary or administrator of the decedent within two years.

The following section of law details the benefits: Section 65-05-19 "Providing Non-Dependency Payments In Certain Cases. If the death of an employee with no surviving spouse or children results from an injury within the time specified in Section 65-06-16, WSI shall pay a lump sum, equal to five percent of the maximum total death benefits in accordance with the current law, to the surviving non-dependent child, or in equal shares to the surviving non-dependent children. In the event that no non-dependent child is living, the sum provided herein shall be paid in equal shares to the surviving parents of the deceased, and if there are none, then to the deceased employee's living brothers and sisters. When there are no living brothers or sisters, the sum herein shall be paid in equal shares to the surviving grandparents, if any, of the deceased employee."

SECTION 1 - Deceased worker's information				
Claim number	Deceased worker's (First name)		(Last name)	Social Security number*
Date of birth	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male		Marital status of deceased worker <input type="checkbox"/> Single <input type="checkbox"/> Married	
Mailing address (Street address, PO Box number)				
City		State	ZIP code	
SECTION 2 - Non-dependent's information				
Non-dependent's (First name)		(Last name)	Social Security number*	Date of birth
Mailing address (Street address, PO Box number)			City	State ZIP code
Telephone number		Relationship to deceased		
Non-dependent's (First name)		(Last name)	Social Security number*	Date of birth
Mailing address (Street address, PO Box number)			City	State ZIP Code
Telephone number		Relationship to deceased		
Please submit a photocopy of the following documents - if available				
<ul style="list-style-type: none"> • Death Certificate • Autopsy Report – if performed 				
SECTION 3 - Accident information				
Date of accident	Time of accident <input type="checkbox"/> AM <input type="checkbox"/> PM		Date of death	
SECTION 4 - Employer's information				
Employer's account number		Employer's name		Employer's telephone number
Mailing address (Street address, PO Box number)				
City		State	ZIP code	

Form continued on next page. Please submit all pages to WSI.

NON DEPENDENT(S) REPORT OF DEATH(cont'd)

SFN 10013 (01/2015)

Claim number	Deceased worker's (First name)	(Last name)
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SECTION 5 – Release of information/fraud warning/signature**Release of information**

I understand and agree that North Dakota law determines all my rights and obligations to and from WSI. I authorize any medical provider or facility, any insurance company, including workers' compensation relating to work injuries, any law enforcement or military agency, any government benefit agency including the Social Security Administration, and any educational agency or institution to release to WSI, its agents and attorneys, any and all information or records, including all prior records as well as those pertaining to mental health, alcohol, or drug abuse, and HIV/AIDS/AIDS-related illness. I authorize healthcare providers to respond to WSI regarding my injury, including request for conclusions and opinions not otherwise contained within existing medical records. In addition, I authorize any educational agency or institution to release to WSI any and all "educational records" as defined by 20 U.S.S. 21 Sec. 1232g. This authorization continues while I have any claim open or pending before WSI. WSI is exempt from HIPAA regulations. I authorize WSI to release any information or records about my claim to third parties or their insurers for the purpose of resolving claims against third parties. I authorize the release of any medical information related to my claim to my employer.

Fraud warning

Any person claiming benefits or compensation from WSI who files a false claim, or makes a false statement, or fails to notify WSI as to the receipt of income or an increase in income from employment, in connection with any claim or application for workers compensation benefits will forfeit any future benefits and may be guilty of a felony which is punishable by imprisonment, substantial fines, or both. These criminal penalties are applicable to all persons dealing with WSI, including injured workers, employers, medical providers, and attorneys.

Signature

By signing this form, I acknowledge that I have read and understand the release of information and fraud warning. I understand that falsifying this claim or making a false statement regarding this claim may be a felony, punishable by substantial fines and imprisonment. I authorize the release of information and agree that statements in this form are true and accurate.

Each beneficiary applying for benefits must sign this application

Applicant's signature	Date signed
Applicant's signature	Date signed

SECTION 6 – Additional information or comments

* In compliance with the Federal Privacy Act of 1974, disclosure of the Social Security number on this form is mandatory pursuant to N.D.C.C. § 65-05-02. The Social Security number is used for identification and verification purposes. Failure to provide this information may result in a delay in processing your request.

To report an instance of fraud, contact the ND Fraud and Safety Hotline at 800-243-3331.

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