North Dakota Workforce Safety & Insurance

SPOUSE/DEPENDENT(S) REPORT OF DEATH

CLAIMS DIVISION
SFN 10012 (09/2015)

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 the deceased worker's surviving spouse and/or dependent(s) or guardian of the dependent child(ren). Application for death benefits must be made by the beneficiary or administrator of the decedent within two years of the date of death.

SECTION 1 – *Deceased worker's information*

Claim number	Deceased worker's (First name)	(Last name)	Social Security number*

Date of birth	Sex ☐ Female ☐ Male	Marital status of deceased worker ☐ Single ☐ Married

Mailing address (Street address, PO Box number)		
City	**State**	**ZIP code**

SECTION 2 – *Surviving spouse/dependent(s) or guardian applying for benefits*

Spouse, dependent or guardian (First name)	(Last name)	Relationship to deceased
Date of birth	**Social Security number***	**Telephone number**

Mailing address (Street address, PO Box number)		
City	**State**	**ZIP code**

List dependents under age 18, or under age 23 if attending school, or incapable of self-support. Use back of form if needed.

Name	Date of birth	Social Security number*	Relationship to deceased

Please submit a photocopy of the following documents – if available

- Death Certificate
- Autopsy Report – if performed
- Marriage Certificate – if applicable

SECTION 3 – *Accident information*

Date of accident	Time of accident ☐ AM ☐ PM	Date of death
Where did accident happen? (City)	**(County)**	**(State)**

How did accident happen?	
Treating doctor(s) name	**Clinic/hospital name**

Clinic/hospital mailing address		
City	**State**	**ZIP code**

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

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Claim number	Deceased worker's (First name)	(Last name)

SECTION 4 – *Employer's information*

Employer's account number	Employer's name	Telephone number
Mailing address (Street address, PO Box number)		
City	State	ZIP code

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.

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.