EMPLOYER'S REPORT OF DEATH

CLAIMS DIVISION
SFN 10011 (09/2015)

North Dakota Workforce Safety & Insurance
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.

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)*

Spouse or dependent(s) (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

SECTION 3 – *Accident information*

Date of accident	Time work started that day ☐ AM ☐ PM		Time of accident ☐ AM ☐ PM	Date of death

Where did accident happen? (City)	(County)	(State)	What was deceased worker hired to do? (Job title or duties)

How did accident happen?

If death was due to heart attack or stroke, was deceased worker under any unusual stress or strain? ☐ Yes ☐ No
If yes, please explain.

Treating doctor(s) name

Address of treating doctor (Street address, PO Box number)

City	State	ZIP code

Name of witness(es) to the accident	Telephone number of witness(es) to the accident

SECTION 4 – *Employer's information*

Employer's account number	Rate class	Employer's name

Mailing address (Street address, PO Box number)

City	State	ZIP code	Telephone number

Do you question this claim? ☐ Yes ☐ No If yes, please explain on the back of this form.

SECTION 5 – *Fraud warning/signature*

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 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 and agree that statements in this form are true and accurate.

Employer's signature	**Title**	**Date signed**	**C9**

* 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.