



**EMPLOYER'S REPORT
OF DEATH**
CLAIMS DIVISION
SFN 10011 (10/2019)

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 employee's information			
Claim number	Deceased employees's (First name)	(Last name)	Social Security number*
Date of birth	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Marital status of deceased employee <input type="checkbox"/> Single <input type="checkbox"/> 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 <input type="checkbox"/> AM <input type="checkbox"/> PM	Time of accident <input type="checkbox"/> AM <input type="checkbox"/> PM	Date of death
Where did accident happen? (City)	(County)	(State)	What was deceased employee hired to do? (Job title or duties)
How did accident happen?			
If death was due to heart attack or stroke, was deceased employee under any unusual stress or strain? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 employees, 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.