CLAIM FOR FUNERAL BENEFITS ONLY

Instructions: This form may not be used if there are any dependents. This form must be completed in its entirety and signed by the filing party. All provisions of address require a complete mailing address. A Certification of Funeral Expenses (WCC Form C-18) must be attached.

Name of Deceased: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Deceased's Social Security Number *(if known)*: _____ **Deceased's Date of Birth:** _____

Name of Filing Party: _____
Address: _____
City: _____ State: _____ Zip Code: _____ Phone Number: _____

Filing Party's Relationship to Deceased (spouse, child, parent, other): _____

I make this claim because:
- ☐ I paid for funeral services and have not been reimbursed.
- ☐ I provided funeral services and have not been compensated.
- ☐ Other: _____

Date of Injury/Disablement: _____

Location Where Accident/Injury Occurred: _____
Address: _____
City: _____ State: _____ ZIP Code: _____

Describe how the accidental injury or, occupational disease occurred:

Date of Death: _____

Cause of Death:

Deceased's Employer Name: _____
Address: _____
City: _____ State: _____ ZIP Code: _____ Phone Number: _____

Pursuant to Labor and Employment Article §9-689(c), I hereby make claim for the reimbursement of costs arising from the funeral of the above-named deceased employee.

I certify that, to the best of my knowledge, information and belief, the deceased employee has no dependents and the information contained herein is accurate. Failure to disclose information or giving false information, may subject the signer to fines, imprisonment, or both, and disqualify you from receiving benefits.

_____ _____
Signature of Person Filing this Claim **Date**

CLICK HERE TO CLEAR FORM

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IMPORTANT: It is the filing party's responsibility to maintain a current mailing address with the Commission. The Commission Claim Number should be included on all correspondence.

Disclosure Pursuant to COMAR 01.01.1983.18

1. The personal information requested on this form is intended to be used in processing your claim under the Maryland workers' compensation laws.
2. Failure to provide the information requested may result in your claim being rejected or a delay in the processing of your claim.
3. You may have a right to inspect, amend and correct the information provided on this form.
4. This form will be made part of your claim file. Portions of your claim file may be subject to public inspection.
5. The information contained on this form is routinely shared with State, Federal or local agencies.

Claim for Funeral Benefits Only Filing Instructions

This form may not be used if there are any dependent claimants. To file a claim for funeral benefits only, this form must be completed, signed and filed. A Certification of Funeral Expenses (WCC Form C-18) must be attached (see instruction 9 below). The Commission does not accept any claim forms, documents or claim-related information via facsimile (FAX) or email.

1. All spaces MUST be typed, or hand printed as clearly as possible in dark or black ink or downloaded from our web page, completed in Adobe Reader and printed from your personal computer (PC).

2. Provide all requested information.

3. Dates must be filled in MM/DD/YYYY (month-day-year) format.

4. When numeric information is not available, zeros MUST be entered.

   Example, Social Security Number: 000000000 (9 zeros). ***You must attach a brief explanation when information is not available.***

5. When there is not sufficient space on the claim form, number additional pages and attach them to the form with a paper clip.

6. DO NOT staple, tape, cross out or otherwise alter the form.

7. A claim form that does not contain the filing party's name and address, the deceased employee's name, the deceased employee's employer's name and address, date of accident or occupational disease, a description of how the accidental injury or occupational disease occurred, or sufficient information to process the claim may be rejected and returned to the filing party.

8. **Sign and date the Claim for Funeral Benefits Only form.**

9. **Certification of Funeral Benefits form must: (1) be signed by the provider of funeral services or mortician; (2) include an attached itemized statement of the services performed and corresponding costs; (3) be signed by the person authorizing the burial or other services; and (4) include the name of the deceased employee.**

10. Mail the completed, signed form and attachments to the Workers' Compensation Commission at the address below.

FAILURE TO FOLLOW THESE INSTRUCTIONS MAY RESULT IN UNNECESSARY DELAY OR RETURN FOR CORRECTION AND RESUBMISSION OF THE CLAIM FORM.