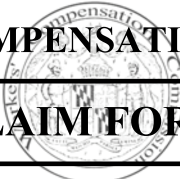

WORKERS' COMPENSATION COMMISSION

DEPENDENT'S CLAIM FOR DEATH BENEFITS

Instructions: The form must be completed in entirety pursuant to the Labor and Employment Article, §§ 9-683.1 through 9-683.5, Annotated Code of Maryland and COMAR 14.09.01.06-1 and must be signed.

Name of Deceased: ______________________________ ______________
First Middle Last — Existent WCC Claim Number of the Deceased

Mailing Address: ______________________________

City ______________ State________ ZIP Code:____________

Individual Filing Claim: ______________________________

Street/Mailing Address: ______________________________

City ______________ State________ ZIP Code:____________

Telephone Number: ( ) ______________

Relationship to Dependent(s): ______________________________

Employer of Deceased: ______________________________

Mailing/Street Address: ______________________________

City ______________ State ________ ZIP Code: ____________

Telephone Number: ( ) ______________ Federal Employer ID (FEIN) ______________

Date of Injury: ______________ **Date of Death:** ______________

State Cause of Injury or Disease: ______________________________

Address Where Injured: ______________________________

City ______________ State________ ZIP Code:

Cause of Death: ☐ Injury ☐ Disease

	Dependent Name	Relationship to the Deceased (Spouse, Child, Other, etc.)
(a)		
(b)		
(c)		
(d)		
(e)		

I hereby make claim as, or on behalf of, a Dependent of the above named Deceased employee and in support thereof make the foregoing statement of facts.

______________________________ ______________
Signature of Person Filing this Claim **Date**

ALL PARTIES' REQUIRED INFORMATION

DECEASED INFORMATION

Name	Social Security No.	Date of Birth	Average Weekly Wage*

Occupation (e.g. police officer, firefighter)

DEPENDENT(S) INFORMATION

(a)

Name	Social Security No.	Date of Birth	Average Weekly Wage*

Street/Mailing Address

City	State	ZIP code

(b)

Name	Social Security No.	Date of Birth	Average Weekly Wage*

Street/Mailing Address

City	State	ZIP code

(c)

Name	Social Security No.	Date of Birth	Average Weekly Wage*

Street/Mailing Address

City	State	ZIP code

(d)

Name	Social Security No.	Date of Birth	Average Weekly Wage*

Street/Mailing Address

City	State	ZIP code

(e)

Name	Social Security No.	Date of Birth	Average Weekly Wage*

Street/Mailing Address

City	State	ZIP code

***Average Weekly wage at the time of injury or disablement, see COMAR14.09.01.07**

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Pursuant to Labor and Employment Article, §§ 9-709, 9-710, and 9-711, Annotated Code of Maryland, and COMAR 14.09.01.06, this authorization must be signed and filed with the Workers' Compensation Commission of Maryland in conjunction with any claim amendment form.

A. Person Covered by Authorization
This document authorizes the disclosure of protected health information regarding:

____ ______________________________
Name of Deceased Employee Date of Birth

____
Social Security Number

B. Purpose of Disclosure

This document authorizes the disclosure of protected health information for the purpose of processing, adjudicating and resolving workers' compensation claims.

C. Entities Authorized to Make Disclosure

This document authorizes any health plan, physician, health care professional, dentist, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to the deceased employee or on my behalf to disclose the deceased employee's protected health information consistent with this directive.

D. Entities Authorized to Receive Protected Health Information

This document authorizes the disclosure of the deceased employee's protected health information to the following entities and their agents: dependent claimant's or the deceased employee's attorney, the deceased employee's employer, the employer's workers' compensation insurer or any agent thereof.

E. Information to be Disclosed

This document authorizes the entities listed in C to disclose protected health information that is relevant to the member of the body that was injured as indicated on the claim form.

The protected health information that may be disclosed includes, but is not limited to: history, findings, office and patient charts, files, examination and progress notes, and physical evidence.

F. I understand that I may revoke this authorization by giving written notice to all parties in my claim for workers' compensation death benefits, except to the extent that this authorization has already been acted on prior to receipt of my revocation.

I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient to a medical manager, health care professional or registered rehabilitation practitioner, and others consistent with state and federal law.

By signing this form, I am authorizing the disclosure of the deceased employee's protected health information. This authorization is valid for one year from the date the amended claim is filed.
Name of

____ ______________________
Signature of Dependent Claimant or Authorized Representative Date

Statement of Authorization:
I am authorized to sign or act on behalf of the dependent claimant because:

A photocopy, facsimile or electronic transmission of this signed authorization form is valid.

Claim Filing Date: ______________________ **WCC Dependent Claim Number:** ____________________

INSTRUCTIONS:

IMPORTANT: It is the Dependent's or the Authorized Representative's responsibility to maintain a current mailing address with the Commission. The Commission Claim Number when assigned should be included on all forms or 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 pursuant to State Government Article, §10-624, Maryland Code Annotated.
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 Filing Instructions (COMAR 14.09.01.06)

ONLY an ORIGINAL claim form obtained from the Workers' Compensation Commission with original signature(s) will be accepted. This form may not be submitted as a photocopy or recreated on office systems; reproductions will be returned to the sender without processing the claim. The Commission does not accept any claim forms, documents or claim-related information via facsimile (FAX) or email (attachment).

1. All form fields must be completed in Adobe Reader (when fillable PDF), printed or typed as clearly as possible in DARK OR BLACK INK.

2. Provide the requested information in each space. Dates must be filled in MMDDYYYY (month-day-year) format. When information is not available, zeros MUST be entered. For example, Social Security Number: 000000000 (9 zeros).

3. Entries may not exceed the length of the space. If information is slightly longer than the space allows, abbreviate without punctuation. When there is not enough space on the form for your information attach additional pages with a paper clip.

4. The Commission may reject and return to the dependent claimant or authorized individual a Dependent's Claim for Death Benefits that does not contain sufficient information to process the claim including:
   a. The dependent claimant's name and, if applicable, the authorized individual's name;
   b. The dependent claimant's address and, if applicable, the authorized individual's address;
   c. The deceased employee's name;
   d. The deceased employee's address;
   e. The deceased employee's date of birth;
   f. The date of the accident or occupational disease;
   g. The member of the deceased employee's body that was injured;
   h. A description of how the accidental injury or occupational disease occurred;
   i. The deceased employee's date of death; and
   j. The deceased employee's employer's name and address.
   k. If the information set forth in §C(2) of COMAR 14.09.01 is unavailable or does not exist the claimant shall:
      i. Enter all zeros (0) in the spaces provided for the information; and
      ii. Attach a signed statement certifying that the information is unavailable or does not exist.
   l. Signature.

5. An authorized individual shall submit documentation establishing his or her authority to act on behalf of the dependent claimant with the claim form.

6. When completing the Dependent's Claim for Death Benefits the dependent claimant or authorized individual shall submit:

a. An authorization for disclosure of health information signed by the dependent claimant or authorized individual, directing the deceased employee's health care providers to disclose to the dependent claimant's attorney, deceased employee's attorney, the deceased employee's employer, the employer's insurer, or any agent thereof, the deceased employee's medical records that are relevant to:
    i. The member of the body that was injured by an accident or occupational disease, as indicated on the claim form; and
    ii. The description of how the accidental injury or occupational disease occurred, as indicated on the claim form;
b. A certification of funeral expenses, if the dependent claimant is making a claim for funeral benefits, which shall:
    i. Include the name of the deceased employee;
    ii. Include an attached itemized statement of the services performed and corresponding costs;
    iii. Be signed by the provider of the funeral services or undertaker;
    iv. Be signed by the person authorizing the burial or other services; and
    v. Be notarized;
c. (c) A certified copy of the certificate of death for the deceased employee;
d. (d) A certified copy of the certificate of marriage for the dependent claimant and deceased employee, if the dependent claimant is the surviving spouse of the employee; and
e. (e) A certified copy of the certificate of birth for the dependent claimant, if the dependent claimant is the surviving child of the deceased employee.

7. The Commission shall reject and return to the dependent claimant or authorized individual a Dependent's Claim for Death Benefits form that does not contain a signed authorization for disclosure of health information.

8. Prior to the scheduled hearing before the Commission on the death claim, the dependent claimant or authorized individual who filed the claim shall submit:

a. Proof of family income at the date of the accidental personal injury or disablement;

b. An affidavit attesting to the authenticity of the documents submitted as proof of family income; and

c. If applicable, copies of any legal documents or orders directing the deceased employee to pay child support or alimony.

Proof of family income may include:

a. Payroll stubs or wage records covering the 14-week period prior to the accidental injury or date of disablement;
b. W-2s;
c. 1099 forms or other evidence of earnings from self-employment; and
d. Tax returns.

9. If the dependent claimant or authorized individual does not have access to proof of income records for some alleged dependent claimants, the dependent claimant or authorized individual shall submit evidence demonstrating the efforts made to obtain these records, including any Commission subpoenas.

10. Date of Filing: A claim is considered filed on the date that a completed and signed claim form, including the signed authorization for disclosure of health information, is received by the Commission. The Commission's date of receipt is determined by the date stamp affixed on the claim form.

Please sign and date the claim form. Read, sign and date the Authorization for Disclosure of Health Information. Claim forms submitted without the necessary signatures on the claim and Authorization for Disclosure of Health Information and attached documentation will be rejected and returned to the filing party.

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

FOR MORE INFORMATION, VISIT:
http://www.wcc.state.md.us