



# Beneficiary Application for Claim Benefits

Language preference (check one):  
 English  Spanish  Russian  Korean  Chinese  Vietnamese  Laotian  Cambodian  Other:

## Deceased Worker

Claim Number		Social Security Number of Deceased Worker	
Name of Deceased Worker		Healthcare Provider Treating Deceased at Time of Death	
Date of Birth	Date of Injury	Date of Death	
Location of Death		Date of Marriage or Registered Domestic Partnership	
Autopsy <input type="checkbox"/> Yes <input type="checkbox"/> No	Cause of Death		
Funeral Home Name		Employer When Injured	
Funeral Home Address		Employer When Injured Address	
City	State	Zip Code + 4	City State Zip Code + 4

## Applicant Information

Name of Applicant	Relationship to Deceased	Date of Birth	Telephone Number
Residence Address		City	State Zip Code + 4
Mailing Address		City	State Zip Code + 4
If you are a spouse or Registered Domestic Partner, were you living at separate addresses on the date of death? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, give the date and cause of separation below.			
Date of Separation	Cause of Separation		
Social Security Number	Date of Divorce or Legal Dissolution from Deceased	Date of Remarriage or New Registered Domestic Partnership since Worker's Death	

## Dependent Children or Stepchildren of Deceased

## Guardian

Name (First, Last)	Date of Birth	Sex	Name of Guardian	Social Security No. (ID only)
			Address	
			City	State Zip Code +4
			Telephone Number	Date of Appointment Date of Birth
<b>Are any of the children between the ages of 18 and 23 in a state institution or enrolled full time in school?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please submit proof.			<b>Please attach a copy of the following documents that apply:</b> A. Death certificate and autopsy if performed. B. Marriage certificate or Declaration of Registered Domestic Partnership. C. Birth certificate(s) of children D. Letters of guardianship or custody order. E. Custody papers for stepchildren. F. Proof of full time enrollment in accredited school of children between ages 18 and 23.	

Persons making false statements in obtaining Industrial Insurance benefits are subject to civil and/or criminal penalties under the law.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Applicant's Signature <b>X</b>	Date
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