Department of Labor and Industries
Division of Insurance Services
PO Box 44282
Olympia WA 98504-4282

CLAIM FOR PENSION BY DEPENDENTS

ALL QUESTIONS MUST BE ANSWERED

Claim #.

Social Security number of deceased

Deceased Worker

Name of deceased worker	Date of birth	Physician at time of death

Date of injury	Date of death	Location where death occurred

Autopsy? Check one	Yes ☐	No ☐	Cause of death

Funeral Home/Mortuary	Employer when injured
Address	Address
City State ZIP+4	City State ZIP+4

Was worker ever married or in a registered domestic partnership? ☐ Yes ☐ No	Date of marriage/registered domestic partnership	If spouse/registered domestic partner died, give date	If relationship terminated, date of divorce or legal dissolution from deceased	If worker was separated, give date

Did worker have children under 18 years of age, a spouse or a registered domestic partnership? ☐ Yes ☐ No	If yes, where are they now?

Person(s) claiming dependency (Both father and mother must join in claim and give necessary details.)

Name (last, first, middle)	Date of birth	Telephone

Resident address of dependent	City	State	ZIP+4

Mailing address of dependent	City	State	ZIP+4

Name (last, first, middle)	Date of birth	Telephone

Resident address of dependent	City	State	ZIP+4

Mailing address of dependent	City	State	Zip+4

Relationship to deceased worker	Are there any other dependents? ☐ Yes ☐ No

Who are the other dependents?

Dependents must answer all of the following questions:	When did you commence to be dependent?

What incapacity (physical/mental/sensory) makes you dependent?

	Have your attending physician give a statement in writing as to your condition and attach it to this claim.

What properties do you own?	What is your indebtedness? $

What was your income for the past year from all sources? $	Give details on amounts of income from each source

Are you a citizen of the U.S.? ☐ Yes ☐ No	If "No", in which country do you have citizenship papers?	*(Proof of citizenship will be required if you reside out of the country)*

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Have you worked during the past year? ☐ Yes ☐ No	How much?	Wages when working $ per

State very specifically the amounts contributed by the deceased to you during one year prior to their death.

Amount	Date	How paid	Amount	Date	How paid
$			$		
$			$		
$			$		
$			$		
$			$		
$			$		
$			$		

Did you reside with the deceased during the year prior to their death? ☐ Yes ☐ No ☐ Part time	If "No", what amount did you pay for board and lodging? $
What other persons or agencies contribute to your support?	

Guardian (If dependents are incompetent, claim must be made through a guardian with proper documents attached.)

Name of guardian	Telephone#	Date of appointment	Date of birth
Address	State ZIP+4		Is guardian acting at this time? ☐ Yes ☐ No

Documents to be attached:

A. Copy of Death Certificate.
B. Copy of Birth Certificate of Applicant.
C. Guardian must send copy of Letters of Guardianship or Custody Order.
D. Receipts, check copies, bank certificates, letters or other documents showing that you received the sums you have set forth above.
E. Certificate from the family physician showing your physical/mental/sensory inability to make a living and thus show your dependency.

Other Instructions:

Claimants are advised that, upon receipt of this claim, the department, if it has not already done so, will write for and procure, the report of death from the attending physician or coroner or an undertaker and such other proofs as may be required, whereupon this claim will be decided.

Give all other facts that you think may assist the department in determining your claim:

SUBSCRIBED AND SWORN TO BEFORE ME THIS DATE
NOTARY PUBLIC
RESIDING AT
MY COMMISSION EXPIRES

All above statements are true and no facts have been concealed.

Today's date	Signature of guardian
Today's date	Signature of dependent