

AWCB Case Number

DEATH BENEFITS REPORT

Complete this form and attach to Compensation Report (Form 07-6104) when you begin, change, suspend or terminate death benefit payments.

1. Deceased Employee's Name (Last, First, Middle Initial)	2. Insurer Claim Number	3. Date of Injury
4. Death Date		5. Social Security Number
6. Place of Death		7. Date of Birth
8. Employer	9. Insurer	
10. Address	11. Address	
City State Zip Telephone	City State Zip Telephone	

12. WIDOW(ER) AND/OR CHILDREN:

a. Name (Last, First, Middle Initial)	Birthdate	Weekly Rate	Date Benefits Terminated
Address	City	State	Zip Code
b. Name (Last, First, Middle Initial)	Birthdate	Weekly Rate	Date Benefits Terminated
Address	City	State	Zip Code
c. Name (Last, First, Middle Initial)	Birthdate	Weekly Rate	Date Benefits Terminated
Address	City	State	Zip Code
d. Name (Last, First, Middle Initial)	Birthdate	Weekly Rate	Date Benefits Terminated
Address	City	State	Zip Code
e. Name (Last, First, Middle Initial)	Birthdate	Weekly Rate	Date Benefits Terminated
Address	City	State	Zip Code
f. Name (Last, First, Middle Initial)	Birthdate	Weekly Rate	Date Benefits Terminated
Address	City	State	Zip Code

13. DEPENDENT PARENTS, GRANDCHILDREN, BROTHER(S) AND/OR SISTER(S):

a. Name (Last, First, Middle Initial)	Relationship	Weekly Rate	Date Benefits Terminated
Address	City	State	Zip Code
b. Name (Last, First, Middle Initial)	Relationship	Weekly Rate	Date Benefits Terminated
Address	City	State	Zip Code
c. Name (Last, First, Middle Initial)	Relationship	Weekly Rate	Date Benefits Terminated
Address	City	State	Zip Code

This is to certify that the original Death Benefits Report and the Compensation Report (Form 07-6104) have been mailed to all dependents at the above address(es), and copies have been mailed to the Alaska Workers' Compensation Board.

14. Name and Title of Person Submitting Report (Print or Type)	15. Signature	Report Date
17. Address	City	State Zip Telephone