FORM 20

Send original to
Court of Existing Claims and 1 copy to
All Other Parties of Record

COURT OF EXISTING CLAIMS
1915 NORTH STILES
OKLAHOMA CITY, OKLAHOMA 73105-4918

THIS SPACE FOR COURT USE ONLY

IN THE MATTER OF THE DEATH OF (PLEASE TYPE OR PRINT)

Full Name of Deceased Employee
Full Name of Person Filing Proof of Loss
Name of Employer
Employer's Insurance Carrier, Permit # for Court Approved Individual Self-Insured or Own Risk Group, Uninsured

PROOF OF LOSS (DEATH CLAIM)
(Lump Sum Benefits)

WCC FILE NO.
Deceased Employee's Social Security Number (LAST 4 DIGITS ONLY) XXX-XX-_____

STATE OF OKLAHOMA)
) SS.
COUNTY OF _____) (PLEASE TYPE OR PRINT)

_____, *(name of person filing proof of loss)* of lawful age, being first duly sworn on oath, alleges and states:

The affiant is the _____, *(relation to deceased employee)* of the deceased employee.

The above named deceased sustained a compensable accidental injury on or about _____, _____ while in the employ of the employer, from and as a result of which the deceased died on _____, _____.

At the time of death, the deceased was lawfully married to _____ *(name of spouse)* whose address is _____ and left surviving the following named children and dependents:

CHILDREN (List additional children on the back of this form.)

FULL NAME	DATE OF BIRTH	ADDRESS
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

DEPENDENTS (Parents, brothers, sisters, grandparents and grandchildren, as defined by and if ACTUALLY DEPENDENT under the workers' compensation laws of Oklahoma. List additional actual dependents on the back of this form. Clearly identify them as "Dependents.")

FULL NAME	DATE OF BIRTH	ADDRESS
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

I affirm I have read this Proof of Loss and declare under penalty of perjury that all statements are true and accurate to the best of my knowledge and belief.

I certify that on _____, _____ I mailed a copy of necessary marriage, birth and death certificates to the opposing party/counsel as noted below. ***NOTE: A certified copy of each of these documents, and other documents necessary to establish actual dependency as defined by law, must be offered at the time of trial or settlement.***

_____
Signature of Person Completing this Proof of Loss DATE

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

I HEREBY CERTIFY THAT A COPY HAS BEEN SENT TO:

Opposing Party	
Address (Number and Street)	
City State Zip Code	

Name of claimant's attorney, if represented OBA #
Address of Attorney (include City, State and Zip Code)
Telephone #
Signature of Claimant's Attorney DATE

C. 02/01/2014