FORM 3A

COURT OF EXISTING CLAIMS
1915 NORTH STILES, STE 127
OKLAHOMA CITY, OK 73105-4918

THIS SPACE FOR COURT USE ONLY

Send original and 4 copies to
Court of Existing Claims

IN THE MATTER OF THE DEATH OF (deceased employee)
Name of Claimant (individual filing claim)
Name of Employer
Court Use Only

☑ Please check appropriate box
☐ I. Original Filing
☐ II. Amends Previously Filed Form 3A (Must clearly state whether amendment is in addition to, or substitute for, prior information.)

CLAIMANT'S FIRST NOTICE OF DEATH AND CLAIM FOR COMPENSATION

WCC FILE NO.

NOTE: Mediation is available to address certain workers' compensation disputes. For information, call (918) 581-2714.

(Please type or print)

DECEASED EMPLOYEE NAME (Last, First, Middle):	Social Security #:	Phone: ( )
Mailing Address (include City, State & Zip):	Date of Birth: Age: Sex:	
Occupation:	Was deceased employment agreement made in Oklahoma? YES ☐ NO ☐	Average Weekly Wage:
Claimant's Name (Last, First, Middle):		Phone: ( )
Mailing Address (include City, State & Zip):		Relationship to Deceased

Date of Accidental Injury	Time: ______________ AM ☐ PM ☐	Place of Injury: City/County/State
Date of Death	Time: ______________ AM ☐ PM ☐	Place of Death: City/County/State
Nature of Injury		Body part(s) injured
Describe activities when injury occurred, with details of how event occurred. Include object or substance which directly injured deceased.		
Cause of death (normally shown on Death Certificate)		Has deceased filed a claim for compensation regarding this accident? YES ☐ NO ☐

Employer:	Federal ID#	Telephone:	
Complete Mailing &/or Street Address:	City:	State:	Zip:

Has a personal representative been appointed for the estate of the deceased? YES ☐ NO ☐ If so, state the name and address below.

____

List names, relationships, addresses and dates of birth of all heirs at law of deceased and any other person who actually depended upon deceased at the time of death. (on the reverse side)

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

Name of claimant's attorney if represented:

Type or Print Name of Attorney:		OBA #
Mailing Address:		
City	State	Zip
Telephone #: ( )		

Upon filing this *Notice of Death And Claim For Compensation*, permission is given to the Administrator of the Court of Existing Claims, the Insurance Commissioner, the Attorney General, a District Attorney or their designees to examine all records relating to the notice, any matter contained in the notice, and any matter related to the notice. The permission to the above persons authorizes them access to medical records pursuant to 76 O.S., §19, including waiver of any privilege granted by law concerning communications made to a physician or health care provider or knowledge obtained by such physician or health care provider by personal examination.

I declare under penalty of perjury that I have examined this *Notice of Death and Claim for Compensation*, and all statements contained herein are true, correct and complete, to the best of my knowledge and belief.

Signed this ______________ day of_____________________, ___________

____
Signature of Attorney for Claimant

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Signature of Claimant (must be signed by claimant)

Rev. 06/24/2015