



BWC Claim Number

Employer: \_\_\_\_\_ Employer's case number: \_\_\_\_\_

Deceased employee: \_\_\_\_\_ Beneficiary: \_\_\_\_\_

The above named (employer or beneficiary) \_\_\_\_\_ hereby gives notice to the Ohio Bureau of Workers' Compensation that the parties hereto have failed to reach an agreement in regard to compensation, etc., to be paid on account of death of the above named employee; and hereby makes Application to said Bureau for the purpose of determining the amount of compensation, etc., to be paid or furnished to said beneficiaries, in accordance with the provisions of Section 27 of the Workers' Compensation Act.

The reason(s) for disagreement are as follows: \_\_\_\_\_

Said applicant, in support of said application, submits the following statement of facts for the consideration of said Bureau:

1. Nature of injury causing death: \_\_\_\_\_

2. Date of injury: \_\_\_\_\_ Time of injury: \_\_\_\_\_ Date of death: \_\_\_\_\_ Time of death: \_\_\_\_\_

3. Employee's wage at time of injury, including bonuses, commission, lodging, etc., .....\$ \_\_\_\_\_

4. This application is made on behalf of the above named beneficiary and the following named persons, who were dependent on deceased for support:

Name	Age	Relationship to deceased	Wholly or partially

5. The following expenses have been incurred for medical and funeral expenses, etc., in the connection with the injury and death of said employee:

Name	To whom paid or due	Amount

By signing this application I expressly waive, on behalf of myself and any person who shall have any interest in this claim, all provisions of law forbidding any physician or other person who has heretofore attended or examined deceased, from disclosing any knowledge or information which they thereby acquired. I have read all the statements contained herein and know the same to be true and correct.

Signed \_\_\_\_\_ (Applicant)

(Address)

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.