

FORM 3A

Send original and 4 copies to
Workers' Compensation Court

WORKERS' COMPENSATION COURT
1915 NORTH STILES
OKLAHOMA CITY, OK 73105-4918

THIS SPACE FOR COURT USE ONLY

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

FILE NO.

NOTE: Mediation is available to address certain workers' compensation disputes. For information, call (405) 522-8760 or in-state toll free (800) 522-8210.

(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 <input type="checkbox"/> NO <input type="checkbox"/>		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 <input type="checkbox"/> PM <input type="checkbox"/>	Place of Injury: City/County/State	
Date of Death	Time: _____ AM <input type="checkbox"/> PM <input type="checkbox"/>	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 <input type="checkbox"/> NO <input type="checkbox"/>	
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)

I declare under penalty of perjury that I have examined this notice and claim, and all statements contained herein, and to the best of my knowledge and belief, they are true, correct and complete.

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

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 Workers' Compensation Court, the Insurance Commissioner, the Attorney General, a district attorney or their designees to examine all records relating to the notice. The permission granted to the above named individuals or their designees authorizes them access to medical records pursuant to Section 19 of Title 76 of the Oklahoma Statutes, 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.

Signed this _____ day of _____, _____

Signature of Attorney for Claimant

Signature of Claimant (must be signed by claimant)