STATE OF CALIFORNIA DEPARTMENT OF INDUSTRIAL RELATIONS DIVISION OF WORKERS' COMPENSATION

FORWARD TO

P.O. BOX 422400 SAN FRANCISCO CA 94142

NOTICE OF EMPLOYEE DEATH

EACH EMPLOYER SHALL NOTIFY THE ADMINISTRATIVE DIRECTOR OF THE DEATH OF EVERY EMPLOYEE REGARDLESS OF THE CAUSE OF DEATH EXCEPT WHERE THE EMPLOYER HAS ACTUAL KNOWLEDGE OR NOTICE THAT THE DECEASED EMPLOYEE LEFT A SURVIVING MINOR CHILD (TITLE 8, CHAPTER 4.5, SECTION 9900). DECEASED EMPLOYEE: AGE: _____ SOCIAL SECURITY NUMBER: ____ NAME: LAST KNOWN ADDRESS: NAME, RELATIONSHIP AND LAST KNOWN ADDRESS OF NEXT OF KIN: JOB TITLE AND NATURE OF DUTIES: DATE, TIME AND PLACE OF ACCIDENT: DATE, TIME AND PLACE OF DEATH: CIRCUMSTANCES OF DEATH (DESCRIBE FULLY THE EVENTS WHICH RESULTED IN DEATH. TELL WHAT HAPPENED. USE ADDITIONAL SHEET IF NECESSARY): CAUSE OF DEATH (ATTACH COPY OF DEATH CERTIFICATE OR CORONER'S REPORT): HAVE ANY WORKERS' COMPENSATION DEATH BENEFITS BEEN PROVIDED IN CONNECTION WITH THIS DEATH? YES NO IF YES, TO WHOM: ATTACH A COPY OF THE FORM 5020. "EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS." IF ONE WAS FILED. PLEASE NOTE: IF THE DEATH IS WORK-RELATED, THE EMPLOYER ALSO IS REQUIRED TO REPORT THE DEATH TO HIS OR HER WORKERS' COMPENSATION INSURANCE CARRIER AND TO THE NEAREST OFFICE OF THE DIVISION OF INDUSTRIAL SAFETY IMMEDIATELY BY TELEPHONE OR TELEGRAPH. AN EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS SHOULD ALSO BE FILED WITH THE WORKERS' COMPENSATION INSURANCE CARRIER. () INSURED () SELF-INSURED () LEGALLY UNINSURED INSURANCE CARRIER EMPLOYER: _____ OR ADJUSTING AGENT: _____ _____ STREET: ____ CITY/STATE: _____ ZIP: ____ CITY/STATE: ____ ZIP: ____ _____ TELEPHONE: __ (INCLUDE AREA CODE) (INCLUDE AREA CODE) TITLE: