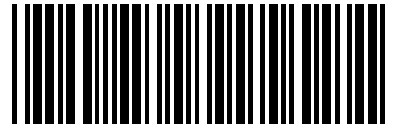


STATE OF CALIFORNIA  
DIVISION OF WORKERS' COMPENSATION  
WORKERS' COMPENSATION APPEALS BOARD  
STIPULATIONS WITH REQUEST FOR AWARD  
(Death Case)



\_\_\_\_\_  
Case Number 1

\_\_\_\_\_  
Case Number 2

**Venue Choice is based upon: (Completion of this section is required)**

- Residence of employee (Labor Code section 5501.5(a)(1))
- Location where injury occurred (Labor Code section 5501.5(a)(2))
- Principal address of employee's attorney (Labor Code section 5501.5(a)(3))

\_\_\_\_\_  
Select 3 Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet)

**Adult Dependent #1 Information**

\_\_\_\_\_  
First Name

\_\_\_\_\_  
MI

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
Address/PO Box (Please leave blank spaces between numbers, names or words)

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

**Adult Dependent #2 Information**

\_\_\_\_\_  
First Name

\_\_\_\_\_  
MI

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
Address/PO Box (Please leave blank spaces between numbers, names or words)

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

---

**Adult Dependent #3 Information**

---

First Name

---

MI

---

Last Name

---

Address/PO Box (Please leave blank spaces between numbers, names or words)

---

City

---

State

---

Zip Code

---

**Employer Information (Completion of this section is required)** Insured Self-Insured Legally Uninsured Uninsured

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Employer Name (Please leave blank spaces between numbers, names or words)

---

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

---

City

---

State

---

Zip Code

---

**Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)**

---

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

---

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

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City

---

State

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Zip Code

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**Claims Administrator Information (if known and if applicable)**

---

Name (Please leave blank spaces between numbers, names or words)

---

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

---

City

---

State

---

Zip Code

The parties to the above-entitled action hereby enter into the following stipulations and request the Division of Workers' Compensation to issue Findings and Award forthwith, without further proceedings.

IT IS HEREBY STIPULATED AS FOLLOWS:



1. That \_\_\_\_\_, age \_\_\_\_\_,  
(First Name) (Last Name) (Years)

while employed at \_\_\_\_\_  
(Place of injury)

as a \_\_\_\_\_  
(Occupation)

by \_\_\_\_\_ on \_\_\_\_\_  
(Name of employer; an individual, co-partnership or corporation) (Date of injury: MM/DD/YYYY)

sustained injury arising out of and occurring in the course of his/her employment, proximately resulting in the death of

said employee on \_\_\_\_\_. That at said time, employer's workers' compensation insurance carrier  
(Date of Death: MM/DD/YYYY)

covering said injury was \_\_\_\_\_, and both the employer and the employee were subject to the provisions of the Labor Code of the State of California.

2. That said employee left surviving him/her, wholly dependent/partially dependent, dependents listed herein: (Give name and if a minor, date of birth and relationship to the employee. Adult dependents are listed above and minor dependents are listed below.)

**Minor dependents**

Minor dependents?



**Minor Dependent # 4 Information**

\_\_\_\_\_  
Name

Minor

\_\_\_\_\_  
Relation Date of Birth: MM/DD/YYYY

**Minor Dependent # 5 Information**

\_\_\_\_\_  
Name

Minor

\_\_\_\_\_  
Relation Date of Birth: MM/DD/YYYY

**Minor Dependent # 6 Information**

\_\_\_\_\_  
Name

Minor

\_\_\_\_\_  
Relation Date of Birth: MM/DD/YYYY

3. That the said dependents are entitled to a death benefit of \$ \_\_\_\_\_  
based upon earnings of \$ \_\_\_\_\_, payable at \$ \_\_\_\_\_ a week.  
(State weekly or monthly wages)



4. That the sum of \$ \_\_\_\_\_ is payable to \_\_\_\_\_  
Total Sum Paid

on account of the burial expense. The sum of \$ \_\_\_\_\_ has previously been paid to \_\_\_\_\_

5. That all necessary medical, surgical and hospital expenses on account of said injury has been paid by defendants.  
(If not paid, explain):

Yes

No



6. That defendants have heretofore paid the sum of \$ \_\_\_\_\_  
on account of death benefit, for which they request credit. Total Death Benefits Paid

7. It is necessary that a guardian ad litem and trustee be appointed for the minors, and the parties request that

\_\_\_\_\_  
First name

\_\_\_\_\_  
Last Name

be appointed such guardian ad litem and trustee.

The Workers' Compensation Administrative Law Judge may assume that no attorney fee is involved in the above-entitled matter and should the facts be otherwise a detailed explanation shall be attached to these stipulations.

\_\_\_\_\_  
Dependent or guardian signature (Date)

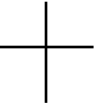
\_\_\_\_\_  
Dependent or guardian signature (Date)

\_\_\_\_\_  
Dependent or guardian signature (Date)

---

**Applicant's Attorney or Authorized Representative:**

Law Firm/Attorney       Non Attorney Representative



First Name \_\_\_\_\_

Last Name \_\_\_\_\_

Law Firm Number \_\_\_\_\_

Law Firm Name \_\_\_\_\_

(Address/PO Box (Please leave blank spaces between numbers, names or words) \_\_\_\_\_)

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Dated \_\_\_\_\_  
MM/DD/YYYY

\_\_\_\_\_  
Applicant Attorney Signature

---

**Defendant's Attorney or Authorized Representative:**

Law Firm/Attorney       Non Attorney Representative

First Name \_\_\_\_\_

Last Name \_\_\_\_\_

Law Firm Number \_\_\_\_\_

Law Firm Name \_\_\_\_\_

(Address/PO Box (Please leave blank spaces between numbers, names or words) \_\_\_\_\_)

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Dated \_\_\_\_\_  
MM/DD/YYYY

\_\_\_\_\_  
Defense Attorney Signature

