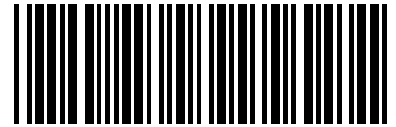




STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
STIPULATIONS WITH REQUEST FOR AWARD
(Death Case)



Case Number 1

Case Number 2

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

- ☐ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)
- ☐ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)
- ☐ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

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

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)

City

State

Zip Code

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

Relation

☐ Minor

Date of Birth: MM/DD/YYYY

Minor Dependent # 5 Information

Name

Relation

☐ Minor

Date of Birth: MM/DD/YYYY

Minor Dependent # 6 Information

Name

Relation

☐ Minor

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)

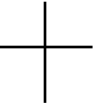
Dependent or guardian signature (Date)

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

