

WID or SSN	
DATE(S) OF CLAIMED INJURY	DATE OF DEATH

Minnesota Department of Labor and Industry  
 Workers' Compensation Division  
 PO Box 64221  
 St. Paul, MN 55164-0221  
 (651) 284-5032 or 1-800-342-5354  
 Fax: 651-284-5731



DO NOT USE THIS SPACE

DECEASED EMPLOYEE	
BY PETITIONER	
VS.	
EMPLOYER(S)	AND
INSURER(S)	AND

## Claim Petition for Dependency Benefits or Payment to Estate

NOTE: File Petition and Affidavit of Service with the Division

**Amended Claim Petition**  
 (to amend a party/date of injury to the claim)

**Amendment to the Claim Petition**  
 (to amend issues(s) relating to this claim)

PRINT IN INK or TYPE  
 ENTER DATES in MM/DD/YYYY FORMAT

*Private or confidential data you supply on this form, and in communications or proceedings that occur because you file this form, will be used to process and resolve your workers' compensation dispute. The data will be used by department of labor and industry (department) staff who have authorized access to the data, and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse your claim may be delayed or denied, or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the office of administrative hearings; the workers' compensation court of appeals; the departments of revenue and health; and the workers' compensation reinsurance association.*

### TO THE WORKERS' COMPENSATION DIVISION, DEPARTMENT OF LABOR AND INDUSTRY

The Petitioner above named alleges the following facts:

- That his/her
1. address is \_\_\_\_\_
2. That the address of the employer is \_\_\_\_\_
3. That on \_\_\_\_\_ the above-named deceased employee sustained an injury or disease and that his/her death on \_\_\_\_\_ was related thereto.
4. That said deceased employee was in the employ of the above-named employer as a \_\_\_\_\_
5. That the deceased employee's weekly wage at the time of said alleged injury or disease was \_\_\_\_\_.
6. That said injury or disease arose out of and in the course of said employment.
7. That the nature of said injury or disease was as follows: \_\_\_\_\_
8. That said employer had knowledge or due notice of the occurrence of the injury, disease and/or death alleged in paragraph 3.
9. That on said date the employer was insured against compensation liability by the insurer or insurers indicated above.
10. That the hospital and medical expenses made necessary by said injury or disease was the sum of \_\_\_\_\_, and that the cost of the funeral and burial was \_\_\_\_\_.
11. That the name and address of any third party who has paid benefits or hospital, medical or burial expenses related to this claim is \_\_\_\_\_
12. That petitioner is \_\_\_\_\_  
 (relationship to deceased employee or dependents)
13. That the following are all of the deceased employee's living dependent children known to petitioner:
 

<u>Name</u>	<u>Address</u>	<u>Birth Date</u>	<u>Type</u>	<u>Amount</u>

  
 Gov't survivor benefits for which dependent is eligible:
14. Other persons dependent on deceased employee (indicate with an \* those who are only partially dependent):
 

<u>Name</u>	<u>Address</u>	<u>Birth Date</u>	<u>Type</u>	<u>Amount</u>

  
 Gov't survivor benefits for which dependent is eligible:
15. That liability has been denied by said employer and/or insurer and no payment of weekly or other benefits has been made except as follows: \_\_\_\_\_

WHEREFORE, Petitioner asks for an award for such benefits as are in such cases provided for by the Workers' Compensation Law of Minnesota, as follows:

- 16. Unpaid benefits payable to employee and now being claimed by dependents \_\_\_\_\_
- 17. Dependency benefits from \_\_\_\_\_ to \_\_\_\_\_
- 18. Rehabilitation benefits for dependent surviving spouse?  Yes  No
- 19. Payment to the estate of the deceased employee under Minn. Stat. § 176.111, subd. 22?  Yes  No

PETITIONER SIGNATURE			ATTORNEY FOR PETITIONER SIGNATURE		
ADDRESS			ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
TELEPHONE			ATTORNEY REGISTRATION #	TELEPHONE	

**TRIAL DATA:**

Request is made for a settlement conference.  Yes  No Estimated hours to present evidence: \_\_\_\_\_

Requested place of: Pretrial \_\_\_\_\_ Trial \_\_\_\_\_

Number of Witnesses: \_\_\_\_ (Attach names and addresses) An Affidavit of Significant Financial Hardship is attached.  Yes  No

If an interpreter is requested for a hearing or conference, specify the language/dialect: \_\_\_\_\_

If a reasonable accommodation of disability is requested for a hearing or conference, describe: \_\_\_\_\_

STATE OF MINNESOTA }  
 COUNTY OF \_\_\_\_\_ } ss.

**AFFIDAVIT OF SERVICE**

I, \_\_\_\_\_, being first duly sworn, state that on \_\_\_\_\_, I served a true and correct copy of this document, enclosed in a properly addressed envelope, by depositing the same, with postage prepaid, in the United States mail at \_\_\_\_\_, Minnesota, addressed as follows:

**NAMES AND ADDRESSES**

Subscribed and sworn to before me \_\_\_\_\_  
 this \_\_\_\_\_ day of \_\_\_\_\_ Signature  
 Notary Public \_\_\_\_\_  
 My Commission expires \_\_\_\_\_

**INSTRUCTIONS**

1. Failure to properly and fully fill out claim petition, with appropriate documentation, in accordance with workers' compensation rules of practice, shall not be considered proper filing under Minn. Stat. § 176.305. The Workers' Compensation Division may refuse to accept a claim petition that lacks any of the following: employee's name, date of injury, WID or social security number, or name of employer/insurer.
2. The claim must be presented in terms of the Minnesota Workers' Compensation Act.
3. If you have more defendants or more injuries than can be listed on the claim petition, it may be modified accordingly.
4. A doctor's report supporting the claim MUST be filed with the claim petition.
5. In listing dependents, refer to Minn. Stat. § 176.111, subd. 1, before completing #13. If the child is over 18 years old, indicate the reasons he/she qualified as a dependent. All other dependents, including spouse, should be listed in #14.
6. The relationship of the petitioner to the deceased employee or to the dependents should be stated in #12 (e.g., widow of deceased employee, or father and natural guardian of children of deceased employee).
7. If additional space is required to list all the dependents claimed, or to list the names, addresses, etc., of third parties making payment of benefits, or hospital, medical or burial expenses, attach a separate sheet containing such information.
8. If no third party has made payment of any benefits, or hospital, medical or burial expenses, enter the word "NONE" in the blank provided for the name and address.
9. The petitioner must serve a copy of the petition on EACH adverse party (employer(s), insurer(s), the Special Compensation Fund, if applicable, and any third party intervenor named in #11) by first class mail or personally.

*This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354/Voice or TDD (651) 297-4198.*

**ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.**



## Instructions for Completing a Claim Petition Form

Use a Claim Petition if you want a hearing with a compensation judge to resolve a dispute where the insurer has denied primary liability for a claim or where the workers' compensation insurer has accepted liability for the claim but is denying wage loss, permanency, and any medical or rehabilitation benefits.

Since the issues typically claimed on the Claim Petition may be complex, you may want to retain the services of an attorney to file the Claim Petition and represent you in the hearing. You will be able to find a workers' compensation attorney by checking the Yellow Pages of your local phone directory or contacting the bar association in your county, which usually have referral services to direct you to an appropriate attorney.

**#1-9 and 12 on the front of the form.** Complete identifying information about employee, employer and the workers' compensation claim itself.

**10a-i.** List the workers' compensation benefits being claimed on the Claim Petition:

**10a-d.** List the wage loss and/or permanent partial disability benefits to which you feel that you are entitled to. Temporary total disability benefits are wage loss benefits you receive when you are off work completely due to the work injury. Temporary partial disability benefits are wage loss benefits you receive when you return to work at a lower wage, due to your injury. Permanent total disability benefits are wage loss benefits you get when you are permanently unable to return to work. Permanent partial disability benefits are monetary benefits you receive to compensate you for a permanent disability (when your doctor gives you a "rating"). Don't worry about the monetary amounts being claimed; just try to list the dates you feel the benefits should have been paid. Attach supporting information, such as an off-work slip from your doctor or a Health Care Provider Report listing the percentage of disability to the whole body, in support of your claim.

**10e-g.** List any medical bills that are unpaid. Attach copies of the bills and supporting medical documentation. Attach additional sheets if necessary to list all the medical providers involved.

**10h.** Fill out this section if you are requesting the services of a Qualified Rehabilitation Consultant (QRC) to help you return to work.

**11.** If your medical treatment has been paid for by a health insurer or you have received short- or long-term disability benefits or unemployment compensation, list them here.

On the back of the form, put in your name, address and telephone number, complete with area code. If you are represented by an attorney, the attorney also gives his or her name, address, telephone number and registration number.

**Trial Data section.** Fill out this section to the best of your ability. Most hearings take 1/2 day. Specify where the hearing should be held - hearings are usually held in St. Paul, Duluth and Detroit Lakes. A settlement conference would be appropriate if you are interested in settling your claim through a process of negotiation. Witnesses, while not required, usually include the injured worker, co-workers who may have witnessed the workers' compensation injury, QRC or vocational experts.

**Affidavit of Significant Hardship.** You may complete a form indicating that you have a significant financial hardship and are requesting an expedited hearing.

**Affidavit of Service section.** Fill out the names and addresses of all the parties to the claim including employer(s), insurer(s), health care providers, any third party that has paid benefits under #11, etc. Fill out and sign the rest of this section in the presence of a Notary Public, who will stamp the form and attest to the true and correct nature of the copy sent through the U.S. mail.

Make a copy of the Claim Petition and each attachment for each of the parties indicated on the back of the form and mail it to each party. Keep a copy for yourself. Mail the original to the Department of Labor and Industry at the address listed on the top of the front of the form.

Additional instructions appear on the bottom of the back page.

If you have questions about how to complete the form, you may call the Alternative Dispute Resolution Unit at: (651) 284-5032 in the Minneapolis/St. Paul metropolitan area, or toll free at 1-800 342-5354 statewide.