FORM F
Fatality
October 2016 Edition

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS
500 Mero Street, 3rd Floor, Frankfort, KY 40601

Workers' Compensation Claim No. _____

IF THIS FORM IS NOT PROPERLY COMPLETED, IT WILL BE RETURNED.
Every section should be completed. If a section is not applicable, fill in the blank with N/A.

_____
Decedent

☐ There are no known dependents

DEPENDENTS

Name	Address	Date of Birth	Relationship to Decedent	Dependent on Decedent at Time of Accident?	Living with Decedent at Time of Accident?

Attach the following if applicable:
1. Marriage License
2. Birth certificate or proof of adoption
3. Court order or proof of guardianship or dependency

OTHER INFORMATION

If additional information is pertinent to settlement, explain:

_____

_____

This the _____day of , 20 .

_____ ___

_____ _____

Attorney (signature) Claimant (signature)