FORM F
Fatality
October 2016 Edition

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS
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? |
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**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)