CC-FORM-3A

USE FOR DEATHS OCCURRING ON OR AFTER FEBRUARY 1, 2014

Send original and 4 copies to:
Workers' Compensation Commission

WORKERS' COMPENSATION COMMISSION
1915 NORTH STILES AVENUE
OKLAHOMA CITY, OK 73105

THIS SPACE FOR COMMISSION USE ONLY

Please check appropriate box

☐ I. Original Filing

☐ II. Amends Previously Filed CC-Form-3A. **(Highlight the change and identify whether it adds to or replaces the prior information.)**

IN THE MATTER OF THE DEATH OF (deceased employee)
Name of Claimant (individual filing claim)
Name of Employer
Commission Use Only

CLAIMANT'S FIRST NOTICE OF DEATH AND CLAIM FOR COMPENSATION

COMMISSION FILE NO.

NOTE: Mediation is available to help resolve certain workers' compensation disputes. For information, call (405) 522-5308 or in-state toll free (855) 291-3612.

(Please type or print)

FULL NAME OF DECEASED EMPLOYEE (Last, First, Middle):	Social Security Number (LAST 4 DIGITS ONLY) XXX-XX-_____	Phone: ( )
Mailing Address (include City, State & Zip):	Date of Birth:	Age: Sex:
Occupation:	Was deceased employment agreement made in Oklahoma? YES ☐ NO ☐	Average Weekly Wage:
Claimant's Name (Last, First, Middle):		Phone: ( )
Mailing Address (include City, State & Zip):		Relationship to Deceased
Date of Accidental Injury	Time: _____ AM ☐ PM ☐	Place of Injury: City/County/State
Date of Death	Time: _____ AM ☐ PM ☐	Place of Death: City/County/State
Nature of Injury		Body part(s) injured
Describe activities when injury occurred, with details of how event occurred. Include object or substance which directly injured deceased.		
Cause of death (normally shown on Death Certificate)		Has deceased filed a claim for compensation regarding this accident? YES ☐ NO ☐
Employer:	Federal ID#	Telephone:
Complete Mailing &/or Street Address:	City:	State: Zip:

Has a personal representative been appointed for the estate of the deceased? YES ☐ NO ☐ If yes, state name and address of the personal representative below:

List, on the reverse side of this form, the names, relationships, addresses and dates of birth of all persons who were actually dependent upon the deceased at the time of death.

List person or entity (with address, phone number) which has paid benefits under a group health, disability or loss of income policy for the injury reported on this form:_____

Administrative Workers' Compensation Act, 85A O.S., §6(A)(1)(a): "Any person or entity who makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who employs any device, scheme, or artifice, or who aids and abets any person for the purpose of: (1) obtaining any benefit or payment … shall be guilty of a felony."

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.

Name of Claimant's Attorney, if represented:

Type or Print Name of Attorney:		OBA #
Mailing Address:		
City	State	Zip
Telephone #: ( )		

The undersigned declare under PENALTY OF PERJURY that they have examined this *Notice of Death and Claim for Compensation*, and all statements contained herein are true, correct and complete, to the best of their knowledge and belief.

Signed this _____ day of_____, _____.

_____
Signature of Claimant (Must be signed by Claimant)

_____
Signature of Attorney for Claimant (if any)

Revised 12-18-14