Reset

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

Office of Administrative Hearings
Workers' Compensation Division
PO Box 64620
St. Paul, MN 551640-0620
(651) 361-7900

CP03

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 OAH
(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 office of administrative hearings (OAH) and the department of labor and industry 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 workers' compensation court of appeals; the departments of revenue and health; and the workers' compensation reinsurance association.

TO: THE OFFICE OF ADMINISTRATIVE HEARINGS

The Petitioner named above alleges the following facts:

1. That his/her 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 to this injury or disease.
4. That the deceased employee was employed by above-named employer as a _____
5. That the deceased employee's weekly wage at the time of the alleged injury or disease was _____.
6. That the injury or disease arose out of and in the course of the employee's employment.
7. That the nature of the injury or disease was as follows: _____
8. That the employer had knowledge or due notice of the occurrence of the injury, disease and/or death alleged in paragraph 3.
9. That on the date of injury the employer was insured against compensation liability by the insurer or insurers indicated above.
10. That the hospital and medical expenses made necessary by the 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:

Name	Address	Birth Date	Gov't survivor benefits for which dependent is eligible: Type	Amount

14. Other persons dependent on deceased employee (indicate with an * those who are only partially dependent):

Name	Address	Birth Date	Gov't survivor benefits for which dependent is eligible: Type	Amount

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: _____

Based on the facts alleged above, 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 }
} ss.
COUNTY OF _____ }

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 _____
Notary Public _____
My Commission expires _____

_____
Signature

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. OAH 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.

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.