PETITION FOR AWARD OF COMPENSATION - FATAL

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0027

PETITIONER

NAME: _____

STREET/P.O. BOX: _____

CITY, STATE, ZIP: _____

TELEPHONE NUMBER: _____

EMPLOYEE SOCIAL SECURITY NUMBER: _____

BOARD FILE NUMBER: _____
(IF KNOWN)

EMPLOYER

NAME: _____

STREET/P.O. BOX: _____

CITY, STATE, ZIP: _____

INSURANCE COMPANY

NAME: _____

STREET/P.O. BOX: _____

CITY, STATE, ZIP: _____

1. On _____ (MONTH), _____ (DAY), _____ (YEAR), _____ (NAME OF DECEASED EMPLOYEE)

   experienced a work-related injury while working for _____ (EMPLOYER NAME).

2. Describe how the injury occurred:

3. Death resulted on: _____ (MONTH) _____ (DAY) _____ (YEAR).

4. Petitioner relationship: _____.

5. List the dependent(s) and respective date(s) of birth: _____

WHEREFORE, the petitioner asks the Board to award the payment of compensation pursuant to 39-A M.R.S.A.

DATED: _____
MONTH DAY YEAR

NAME OF PETITIONER'S ATTORNEY OR ADVOCATE (IF ANY)

STREET/P.O. BOX

CITY, STATE, ZIP

FILING INSTRUCTIONS

1. Mail original petition to the Workers= Compensation Board at the above address by regular mail.
2. Mail one (1) copy **by certified mail, return receipt requested** to the insurance company.
3. Mail one (1) copy **by certified mail, return receipt requested** to the employer.
4. Keep one (1) copy for yourself and keep the green certified mail cards when returned to you by the U.S. Post Office.

THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY (877) 832-5525