

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS

500 Mero Street, 3rd Floor, Frankfort, KY 40601

Workers' Compensation Claim no. _____
 Before _____

Request to Substitute Party and Continue Benefits

The undersigned, being a dependent of the deceased plaintiff/employee, requests to be substituted as the Plaintiff/employee for the purpose of receipt of benefits, and further states as follows:

1. *Employee/Plaintiff: _____ *SSN/Greencard: _____
2. *Date of death (attach copy of certified Death Certificate): _____
3. *Cause of death: _____
4. Date of Award/Settlement and amount: _____
5. Name and address of party paying benefits:

6. Date of Marriage (attach copy of certified Marriage License): _____

7. List of dependent(s) requesting substitution (attach copies of certified Birth Certificates):

NAME	SSN/GREEN CARD	DATE OF BIRTH	RELATIONSHIP	ADDRESS (mailing address, city, state, postal code)

Is decedent/employee survived by any minor dependents other than those listed above? Yes No

If yes, please list below:

Name	Mailing Address, City, State, Postal Code	Date of Birth	Guardian/Custodial

Wherefore, the dependent requests that he/she be substituted as the Plaintiff/Employee and that said benefits be paid directly to him/her.

The undersigned hereby states that the foregoing is true and accurate to the best of my knowledge and belief and so attests under penalty of perjury.

Respectfully submitted,

Signature

Mailing Address

Relationship to decedent

City/State/Postal Code

Phone number

Country

I certify that copies were served this _____ day of _____, 20____ to:

Defendant/Employer or Attorney for Defendant/Employer:

Other Parties (if applicable):

Notice: Any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.