Form F - Fatality
October 2016 Edition

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS
657 CHAMBERLIN AVENUE, FRANKFORT, KY40601

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

_____
Decedant

☐ There are no known dependents

DEPENDENTS

Name	Address	Date of Birth	Relationship to Decedent	Dependent or Decedent at Time of Accident?	Living with Decedent at Time of Accident?

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)