PETITION FOR AWARD OF COMPENSATION - FATAL

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

PETITIONER		EMPLOYER		
NAME:	N	NAME:		
STREET/P.O. BOX:		STREET/P.O. BOX:		
	C	CITY, STATE, ZIP:		
TELEPHONE NUMBER:				
RELATIONSHIP TO DECEASED:		INSUR	ER	
EMPLOYEE NAME:				
DATE OF BIRTH:		INAIVIE.		
EMPLOYEE SOCIAL SECURITY NUMBER: XXX-XX-		STREET/P.O. BOX:		
(only last four digits required) BOARD FILE NUMBER:		CITY, STATE, ZIP:		
BOARD FILE NOMBER.	NOTIC			
incapacity or death benefits, however employee must be paid total benefits accordance with 39-A M.R.S.A. §205 1. On,	, with credit for earnings an (2) and in compliance with	d other statutory offsets, from t 39-A M.R.S.A. §204.		
MONTH DAY YEAR NAME OF DECEASED EMPLOYEE				
injury while working for	EMPLOYER NAME			
The injury occurred Month DA Dependents of deceased employe	Y YEAR .	OW THE INJURY HAPPENED	<u>.</u>	
Name	Date of Birth	Relationship to Deceased		
THEREFORE, the petitioner asks the		rsuant to Title 39 or 39-A. DATED:	DAY YEAR	
EII ING INICTRUCTIO	NC.			
FILING INSTRUCTION	ONS	NAME OF PETITIONER'S ATTORN	IEY OR ADVOCATE (IF ANY)	
 Mail original petition to the Workers' Compensation Board at the above address by regular mail. 		STREET/P.0	STREET/P.O. BOX	
2. Mail one (1) copy by certified mail, retur each other party named in the petition.	n receipt requested to	CITY, STAT	E, ZIP	
Keep one (1) copy for yourself and keep the green certified mail		, -		
cards when returned to you by the U.S. Post Office.		TELEPHONE I	TELEPHONE NUMBER	

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: (888) 801-9087 or TTY Maine Relay 711. WCB-150 (eff. 1/1/13)