WCC CASE NO.:

# FORM DB-E1

## EMPLOYER RESPONSE ON DEATH BENEFIT CLAIM BEFORE THE WCC

Instructions: Upon receiving of the official notice of a claim filed by a Petitioner on behalf of the decedent (Employee) for death benefits, the employer is directed to provide a response to the filed claim. The employer must complete and submit this form within 14-calendar days upon receipt of the claim notice to the Commission's Office, as well as the submission of all documentations as required by this form. If an attorney is involved or retained, the employer is fully advice to collaborate with the attorney in completing this form.

| 1. Date of this Report: | 2. Date of Death: | 3. Decedent's Name (Employee): | 4. Employee's Occupation: |
|---|---|---|---|
| 5. Employer's Name: | | 6. Employer's WC Insurance Carrier: | 7. Date Employee was Hired by the Employer: |

**8. Date – Employer's First-Knowledge of Employee's Death:**

**9. Did employee's death occurred while performing work duties during working hours?**

☐ Yes | ☐ No

**10. Location or Occurrence of Employee's death:**

☐ Employer's Place of Business / Office

☐ Other (specify):

**11. Employee's Hourly Rate:**

**12. Employee's Wages / Salary:**

$_____ : ☐ Weekly | ☐ Annual

**13. Were there any other employees died from the same accident?**

☐ Yes – how many? _____ | ☐ No

**14. Did the employer provided the proper equipment, tools, and safety gear and other related safety apparel for the employee to perform his or her job on the date of death?**

☐ Yes | ☐ No | ☐ Employee did not use it

☐ Not applicable – specify reason why:

**15. Is the employee death caused by defective tools, equipment, or supplies?**

☐ Yes | ☐ No

**16. Was employee's death due to intoxication?**

☐ Yes | ☐ No

**17. Was employee's death due to intent to injured him or herself?**

☐ Yes | ☐ No

**18. Is the cause of death caused by another person?**

☐ Yes – Provide name: _____ | ☐ No

**19. Did employee suffer any work-related injury in the last 5 years at work?**

☐ Yes – when? _____ | ☐ No

**20. Was the employee assigned additional work duties requiring enormous physicality and time during the last month or week before his or her death?**

☐ No – Regular / Usual duties | ☐ Yes

**21. Did employer know or fully aware of the employee having pre-existing medical conditions or disability during hiring?**

☐ Yes | ☐ No

**22. In regards to the death benefit claim filed before the Commission, does the employer contest and dispute the claim filed by the Petitioner?**

☐ NO – the Employer acknowledges that the employee's death as filed and reported is work-related;

☐ YES – the Employer contests and controverts right to compensation due the employee's death as not work-related or reasons warranted by provisions of the American Samoa Workmen's Compensation Act. *** Important Note: If a claim is disputed and controvert, a FORM PER-37: NOTICE TO CONTROVER CLAIM must be filed with the Commissioner within 14-days after the employer has knowledge of the alleged injury, or upon receipt of claim notice. Please make sure to furnish and provide a FORM PER-37 with this form.

**23. Name of Person Signing this Report:**

**24. Position or Title of Person Signing this Report:**

**25. Authorized Signature:**

X _____.

FILED

*** AUTHORIZED OWCC PERONNEL ONLY ***

FORM DISTRIBUTION:

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