


CLAIM FOR DEATH BENEFITS

1. Name of Deceased Employee: (First, Middle, Last)		2. Social Security No.:		3. Nationality:		4. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		5. Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Not Married		6. Date of Birth:	
7. Name of Employer:			8. Employee's Occupation:			9. How long have employee employed with Employer?					
10. Date of Death: (Month/Day/Year)		11. Time of Death: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM		12. Location or Occurrence of Employee's Death: <input type="checkbox"/> At place of employment <input type="checkbox"/> Outside place of employment (specify): _____							
13. Employee's Mailing Address:			Employee's Telephone No.:			14. Name of Petitioner Filing Claim on Behalf of the Employee:					
			Valid Email Address (if any):			15. Name of Attorney Retained to Represent Petitioner – if any:					
16. Total surviving or dependent children under the age of 18 years old:			17. If there is no surviving spouse or child, please indicate if any of the following are dependents of the employee at the time of death and are also verified as so in the employee's income tax filed one year prior to his or her death: <input type="checkbox"/> Grandkids (under 18Yrs. Old) <input type="checkbox"/> Siblings (under 18Yrs. Old) <input type="checkbox"/> Parents <input type="checkbox"/> Grandparents								
18. Total funeral expenses for claim:		19. Total medical billing claim for payment (e.g.; morgue fees, etc.):				20. Total paid medical billing for reimbursement:					
21. Names of the employee's surviving or dependent spouse and all surviving or dependent child under the age of 18 years old (if any); Or if applicable, the names of all other dependents specified under Question 17 if there is no surviving spouse or child:											
Name			Relationship			Social Security No.			Birthdate		
22. DESCRIPTION – Briefly described what happen on the date of employee's death; how did the employee's death occurred; and what attributed or caused the employee's death. (May attach a separate written document if prefer):											
23. Reason for Filing Death Benefit Claim before the Commission:											
<input type="checkbox"/> Claim disputed and controverted entirely by employer as work related. <input type="checkbox"/> Employer or carrier accepts claim but not certain benefits. <input type="checkbox"/> Petitioner do not agree with the settlement by carrier or employer <input type="checkbox"/> Claim awarded but carrier or employer have not made payments.											
24. AUTHORIZATION: <i>I hereby verify as the Petitioner or the representing Attorney filing before the Commission a death benefit claim on behalf of the deceased Employee (Claimant) whose death is being claimed as work-related. I acknowledge and understand that any failure to file such claim within the prescribed period will not bar such claim from filing unless such failure is made known at the Claimant's first informal hearing. I duly affirmed that all the information, records, and documentations disclosed within and provided together with this form are both true and not fraudulent. I also agree to authorize upon request of the Commission and its office any physician or doctor and/or hospital or medical institution to furnish and release any medical record, report, or evaluation concerning the employee's death.</i>						FILED *** AUTHORIZED OWCC PERONNEL ONLY ***					
(Print & Sign): _____ NAME & SIGNATURE OF PERSON MAKING THIS CLAIM:											
DATE: _____											

INSTRUCTIONS ON FILING THE DEATH BENEFIT CLAIM FORM (DB-01):

Complete this form and submit directly to the Commission's Office together with all the documentations and records as required under this form during filing, including payment of the application fee. Please submit and provide only the form portion on top. Electronic submission of the filing application via online is prohibited. Form may be submitted directly to the Commission's Office or be delivered to the following mailing address:

Office of the Workmen's Compensation Commission
P.O. Box 39
Pago Pago, American Samoa 96799

A death benefit claim may be filed within one year from the date of injury, or within one year after the dependents know or by exercise of reasonable diligence should know the possible relationship of the death to the employment. Failing to file a claim within the prescribed period will not bar a claim from filing unless an objection is raised during the claimant's first informal hearing.

REQUIRED DOCUMENTATIONS TO FURNISH & SUBMIT WITH FORM DB-01 DURING FILING

- (a) Employee's medical report from all medical institutions.
- (b) Copy of the employee's marriage certificate - if married.
- (c) Copy of birth certificates for all surviving child or dependent siblings under 18years old.
- (d) Copy of the employee's filed income tax filed one year prior before employee's death
- (e) Employee's Personnel Form-303 (for ASG Employees).
- (f) Record of employment status from employer (for Private Sector Employees).
- (g) Employee's check stubs issued since the date of death.
- (h) Submission of names and written statements from at least 3 witnesses - if any.
- (i) Remaining or outstanding medical billings prior to the employee's death for payment (e.g. morgue fees, embalm fee, etc.). If such billings have been paid out-of-pocket, valid receipts must be provided as proof for reimbursement.
- (j) Proof of paid invoices and receipts on funeral expenses.
- (k) Other documentation, reports, and records requested by the Commission.

DESCRIPTION OF DEATH BENEFITS [A.S.C.A. §32.0617]

- (a) 35% of the decedent's average weekly wages to the surviving or dependent spouse.
- (b) 15% of the decedent's to each surviving or dependent children.
 - 35% if there's only one child and no surviving spouse.
- (c) If no surviving or dependent spouse or child (or if the amount payable to a surviving or dependent spouse and children be less in the aggregate than 66-2/3% of the decedent's average wages), the following will be eligible for support. To qualify, all must be filed dependents of the employee before or on the time of his or her death:
 - 15% of decedent's average weekly wages to decedent's grandkids under 18yrs. old
 - 15% of decedent's average weekly wages to decedent's siblings under 18yrs. old
 - 25% of decedent's average weekly wages to each of the decedent's parents
 - 25% of decedent's average weekly wages to each of the decedent's grandparents
- (d) Reasonable funeral expenses not to exceed \$1,000.00.
- (e) Payment of any outstanding medical billings related to the employee's death (e.g., morgue fees, etc.)
- (f) Reimbursement of any medical billings related to the employee's death paid out-of-pocket.