

State of Utah - Labor Commission
Adjudication Division
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 Salt Lake City, Utah 84114-6615
 (801) 530-6800
 casefiling@utah.gov
Note: PLEASE TYPE OR PRINT IN BLACK INK

<p>_____</p> <p>Petitioner</p> <p>_____</p> <p>Decedent</p> <p>vs.</p> <p>_____</p> <p>Respondent (employer)</p> <p>_____</p> <p>Respondent's mailing address</p> <p>_____</p> <p>City, State and Zip Code</p> <p>_____</p> <p>Respondent's phone number</p> <p>_____</p> <p>Respondent's workers' comp Insurance Carrier</p> <p>_____</p> <p>Insurance Carrier's mailing address</p> <p>_____</p> <p>City, State and Zip Code</p> <p>_____</p> <p>Insurance Carrier's phone number</p>	<p style="text-align: center;">APPLICATION FOR HEARING-DEPENDENT'S BENEFITS and/or BURIAL BENEFITS</p> <p style="text-align: center;">Occupational Disease Claim</p> <p>If deceased employee was employed for less than one year at his/her last employer where the injurious exposure occurred, you must file a separate Application for Hearing for each previous employer where employee suffered an injurious exposure.</p> <p>(NOTE: Include all supporting documentation when this form is filed with the Labor Commission or the Application for Hearing may be returned)</p> <p>I request to have a Claims Resolution Conference scheduled to resolve the issues checked below</p> <p style="text-align: center;"><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
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PETITIONER UNDER TITLE 34A APPLIES FOR DEPENDENT'S BENEFITS and/or BURIAL ALLOWANCE, AND ALLEGES:

1. The decedent died by occupational exposure arising out of and in the course of decedent's employment with the above named employer, which occupational exposure occurred from Month _____ Date _____ Year _____ to Month _____ Date _____ Year _____

2. The occupational exposure occurred at the following location:

3. The occupational exposure resulted from either the following repetitive work activities, or harmful substances:

4. The cause of death was: _____

5. The decedent's date of death was: Month _____ Date _____ Year _____.

6. At the time of the occupational exposure at issue: the decedent's wage was \$_____ per _____, and decedent was working _____ hours per week. Decedent was _____ was not _____ married and had _____ dependent children.

7. The decedent had the following dependents at the time of the occupational exposure at issue:

NAME	RELATIONSHIP	BIRTH DATE	PRESENT ADDRESS	SOCIAL SECURITY NUMBER

Petitioner verifies that the above information is true and correct to the best of petitioner's information and belief.	
_____ Printed Name of Attorney for Petitioner State Bar #	_____ Signature of Petitioner Date
_____ Signature of Attorney for Petitioner	_____ Mailing Address of Petitioner
_____ Mailing Address for Attorney for Petitioner	_____ City/State/Zip Code
_____ City/State/Zip Code	_____ Petitioner's Telephone Number
_____ Telephone Number	_____ Petitioner's Social Security Number
_____ FAX E-Mail Address	_____ Petitioner's E-Mail Address

DOCUMENTS THAT MUST BE FILED WITH APPLICATION FOR HEARING

IMPORTANT: Failure to include completed and signed forms with all requested supporting documentation will result in the Application for Hearing being returned for completion. If the returned Application for Hearing is not completed and re-filed with the requested supporting documents within sixty (60) days, the Application for Hearing will be dismissed.

1. **Decedent's Death Certificate.**
2. Documents supporting dependency relationship with the decedent.
3. Minor Dependents' birth certificates.
4. Guardianship or Conservatorship Documents for Petitioner. (Only required if filing on behalf of minor children other than petitioner's own children).

If you know the name and address of the adjuster or third party administrator that you have dealt with concerning your claim please include that information:

Name of adjuster or third party administrator

Mailing Address for adjuster or third party administrator

City/State/Zip Code

E-mail Address