CONTINUED DEPENDENTS' BENEFITS DECLARATION
Utah Labor Commission Case Number _____
Decedent's Full Name _____

Continued Dependency for Minor Children:
Applicant's Full Name: _____
Applicant's Mailing Address: _____
City/State/Zip: _____
Applicant's Daytime Telephone Number: _____ (where you may be contacted)
Relationship of applicant to minor child(ren): _____

If you are not a parent to the minor child(ren), please attach an explanation and all related legal documents.

Please complete the following for the decedent's minor child(ren) currently residing with the applicant:

Name	Date of Birth	Expected High School Graduation Date	Total Monthly Social Security Death Benefit Child Receives
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list the name(s)of the decedent's minor child(ren) for whom you are responsible to support who are not living with the applicant and attach a separate sheet explaining the circumstances:_____

Application for Surviving Spouse Continued Dependency:
By filling in this portion and signing below, I represent that I am the decedent's surviving spouse and that I am still dependent upon workers compensation benefits and that my current standard of living is the same or below what it was at the time of the fatal industrial accident or occupational disease. (Note: The carrier or self insured employer may ask you to provide additional financial information to evaluate your claim.)
Full Name: _____
Mailing Address:_____
City/State/Zip_____
Daytime Telephone Number: _____(where you may be contacted)
Date of Birth: _____
Current Marital Status: _____
Do you plan to change your marital status within the next year? Yes __ No __ If yes, on what date?_____
Amount of monthly Social Security death benefits received, if any: _____
Please list the names of all people residing in your household and their relationship to you:
_____
_____
_____
Signature of Surviving Spouse: _____ Date _____

Application for Continued Dependency of Other Adult Dependent(s):
By filling in this portion and signing below, I represent that I am still dependent upon workers compensation benefits. (Note: The carrier or self insured employer may ask you to provide additional information to evaluate your claim.)
Full Name: _____
Mailing Address: _____
City/State/Zip: _____
Daytime Telephone number:_____(where contact can be made about this claim)
Relationship to Decedent: _____
Amount of monthly Social Security death benefits received, if any: _____
State the reason(s) you are still dependent upon workers compensation benefits: _____
_____
_____
Signature: _____ Date: _____