

**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: \_\_\_\_\_