Form 151

DEPENDENT'S BENEFIT INFORMATION

PLEASE PRINT OR TYPE

Insurance Carrier Claim Number _____Name of Decedent _____

Date of Industrial Injury or Occupational Disease _____Date of Death_____

Employer Name _____ Industrial Carrier/TPA (circle one) _____

JOB(s) ON DATE CLAIM AROSE	WAGE PER HOUR	HOURS WORKED PER WEEK
TOTAL WAGES PER WEEK FOR ALL JOBS		=

Dependent Information

NAME	RELATIONSHIP	BIRTH DATE	PRESENT ADDRESS (Including State/City/Zip)

This claim has been (check one): Accepted in full _____ Accepted in part _____ Denied _____
If all or part of the claim has been denied, please attach Form 089 -"Employee Notification of Denial of Claim."
ADJUSTER/AUTHORIZED AGENT CONTACT INFORMATION
Name_____Signature_____
Mailing Address _____
City/State/Zip _____
Telephone Number _____ FAX Number _____