

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 _____



Official Form 151 Revised 2/09

State of Utah • Labor Commission • Division of Industrial Accidents

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