

# 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
<b>TOTAL WAGES PER WEEK FOR ALL JOBS</b>		=

**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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