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# STATE OF CALIFORNIA
# DIVISION OF WORKERS' COMPENSATION
# WORKERS' COMPENSATION APPEALS BOARD
# STIPULATIONS WITH REQUEST FOR AWARD
# (Death Case)

Case Number 1

Case Number 2

**Venue Choice is based upon: (Completion of this section is required)**

- ☐ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)
- ☐ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)
- ☐ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

Select 3 Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet)

**Adult Dependent #1 Information**

First Name MI

Last Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

**Adult Dependent #2 Information**

First Name MI

Last Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

**Adult Dependent #3 Information**

First Name | MI

Last Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

**Employer Information (Completion of this section is required)**

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

**Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)**

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

**Claims Administrator Information (if known and if applicable)**

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

The parties to the above-entitled action hereby enter into the following stipulations and request the Division of Workers' Compensation to issue Findings and Award forthwith, without further proceedings.

IT IS HEREBY STIPULATED AS FOLLOWS:

1. That _____ _____ , age _____ ,
(First Name) (Last Name) (Years)

while employed at _____
(Place of injury)

as a _____
(Occupation)

by _____ on _____
(Name of employer; an individual, co-partnership or corporation) (Date of injury: MM/DD/YYYY)

sustained injury arising out of and occurring in the course of his/her employment, proximately resulting in the death of

said employee on _____ . That at said time, employer's workers' compensation insurance carrier
(Date of Death: MM/DD/YYYY)

covering said injury was _____, and both the employer

and the employee were subject to the provisions of the Labor Code of the State of California.

2. That said employee left surviving him/her, wholly dependent/partially dependent, dependents listed herein: (Give name and if a minor, date of birth and relationship to the employee. Adult dependents are listed above and minor dependents are listed below.)

**Minor dependents**

☐ Minor dependents?

**Minor Dependent # 4 Information**

_____
Name

_____ ☐ Minor _____
Relation Date of Birth: MM/DD/YYYY

**Minor Dependent # 5 Information**

_____
Name

_____ ☐ Minor _____
Relation Date of Birth: MM/DD/YYYY

**Minor Dependent # 6 Information**

_____
Name

_____ ☐ Minor _____
Relation Date of Birth: MM/DD/YYYY

3. That the said dependents are entitled to a death benefit of $ _____

based upon earnings of $ _____ , payable at $ _____ a week.
(State weekly or monthly wages)

4. That the sum of $ _____ is payable to _____
Total Sum Paid

on account of the burial expense. The sum of $ _____ has previously been paid to

_____

5. That all necessary medical, surgical and hospital expenses on account of said injury has been paid by defendants. (If not paid, explain):

☐ Yes

☐ No

6. That defendants have heretofore paid the sum of $ _____
Total Death Benefits Paid
on account of death benefit, for which they request credit.

7. It is necessary that a guardian ad litem and trustee be appointed for the minors, and the parties request that

_____
First name

_____
Last Name

be appointed such guardian ad litem and trustee.

The Workers' Compensation Administrative Law Judge may assume that no attorney fee is involved in the above-entitled matter and should the facts be otherwise a detailed explanation shall be attached to these stipulations.

_____
Dependent or guardian signature (Date)

_____
Dependent or guardian signature (Date)

_____
Dependent or guardian signature (Date)

**Applicant's Attorney or Authorized Representative:**

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Law Firm Number

Law Firm Name

(Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Dated MM/DD/YYYY

Applicant Attorney Signature

**Defendant's Attorney or Authorized Representative:**

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Law Firm Number

Law Firm Name

(Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Dated MM/DD/YYYY

Defense Attorney Signature