

SUPPLEMENTAL REPORT FOR FATAL ACCIDENTS
(FORM 19, EMPLOYER'S REPORT OF EMPLOYEE'S INJURY TO THE
INDUSTRIAL COMMISSION, MUST ALSO BE SUBMITTED IN EVERY CASE)

IC File # _____

Emp. Code # _____

Carrier Code # _____
The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence. Code numbers assigned to each employer and carrier should be inserted before mailing.

The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act

Deceased Employee's Name _____	Employer's Name _____ Telephone Number _____
Address _____	Employer's Address _____ City _____ State _____ Zip _____
City _____ State _____ Zip _____	Insurance Carrier _____
Home Telephone _____ Work Telephone _____	Carrier's Address _____ City _____ State _____ Zip _____
XXX-XX- _____ <input type="checkbox"/> M <input type="checkbox"/> F / /	() ()
Last 4 Digits of SSN _____ Sex _____ Date of Birth _____	Carrier's Telephone Number _____ Fax Number _____

1. Date of accident: _____ 2. Date of death: _____, 20__

3. Dependents, or if employee left no dependents, next of kin: (Indicate which are non-resident aliens)

Name	Date of Birth	Relationship	Present Address
a. _____	_____	_____	_____
b. _____	_____	_____	_____
c. _____	_____	_____	_____
d. _____	_____	_____	_____
e. _____	_____	_____	_____
f. _____	_____	_____	_____

4. Immediate cause of death: _____

5. Amount of burial expenses authorized \$ _____

Signature of Employer or Carrier/Administrator _____ Title _____ Date _____