

**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 # \_\_\_\_\_

Employer FEIN \_\_\_\_\_

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 \_\_\_\_\_

M  F / /

( ) \_\_\_\_\_ ( ) \_\_\_\_\_

Social Security Number \_\_\_\_\_ 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 \_\_\_\_\_