

**INDUSTRIAL ACCIDENT BOARD**  
**STATE OF DELAWARE**  
**STATEMENT OF FACTS FOR DEATH CLAIM**

1. **Name of Employee:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Telephone No.:** \_\_\_\_\_ **E-mail (optional):** \_\_\_\_\_

2. **Date of Accident:** \_\_\_\_\_

3. **Place of Accident:** \_\_\_\_\_

4. **Name of Employer:** \_\_\_\_\_  
**Employer Contact:** \_\_\_\_\_ **E-mail (optional):** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Telephone No.:** \_\_\_\_\_ **Facsimile No.:** \_\_\_\_\_

5. **Name of Insurance Carrier / Third Party Administrator:** \_\_\_\_\_

6. **Occupation of Employee at the time of Accident:** \_\_\_\_\_

7. **Describe the ACCIDENT and how it happened (attach a separate sheet if more space needed):**  
\_\_\_\_\_  
\_\_\_\_\_

8. **Describe the NATURE OF INJURY to the INJURED BODY PARTS (attach a separate sheet if more space needed):**  
\_\_\_\_\_  
\_\_\_\_\_

9. **Did Employee receive medical, surgical or hospital service:** YES NO

10. **When was notice of injury given to or received by Employer:** \_\_\_\_\_

11. **Give names and addresses of all employers in PAST 5 YEARS (attach a separate sheet if more space needed):**

NAME:	ADDRESS:
_____	_____
_____	_____
_____	_____
_____	_____

12. **State Employee's average weekly wage when injured:** \_\_\_\_\_

13. **Give names and addresses of every treating doctor in LAST 10 YEARS (attach a separate sheet if more space needed):**

NAME:	ADDRESS:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

14. State number of weeks employed during the last twelve months: \_\_\_\_\_

15. State at what trade or occupation employed during the last twelve months:  
\_\_\_\_\_  
\_\_\_\_\_

16. Date of Employee's death: \_\_\_\_\_

17. What were the expenses of last sickness and burial:  
\_\_\_\_\_  
\_\_\_\_\_

18. What amount of these expenses were paid by the Employer:  
\_\_\_\_\_  
\_\_\_\_\_

19. Name of widow or widower of deceased, if dependent:  
\_\_\_\_\_

20. Names and dates of birth of dependent children under sixteen years of age:  
NAME: BIRTH DATE:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

21. Names and addresses of surviving father and mother of deceased, if dependent:  
NAME: ADDRESS:  
\_\_\_\_\_  
\_\_\_\_\_

22. Names and dates of birth of dependent siblings of deceased under sixteen years of age:  
NAME: BIRTH DATE:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

23. State any other important facts bearing on the claim above presented:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DATED THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, A.D. \_\_\_\_\_

I swear or affirm that the information contained in this statement is true and correct to the best of my knowledge and recollection. I understand and acknowledge that any falsehood contained in this statement may expose me to civil or criminal liability.

\_\_\_\_\_  
**DEPENDENT SIGNATURE**