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| **South Carolina Workers’ Compensation Commission**  1333 Main Street, Suite 500 ● Post Office Box 1715  Columbia, South Carolina 29202-1715  (803) 737-5723 [www.wcc.sc.gov](http://www.wcc.sc.gov) | | | SCSealBWjpg | | | |  |  | | --- | --- | | WCC File #: |  | |  |  | | Carrier File #: |  | |  |  | | Carrier Code #: |  | |  |  | | Employer FEIN #: |  | |  |  | | |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Claimant's Name: | | |  | | | SSN: | | -  - | | |  | |  | | | | | | | | | Address: | |  | | | | | | | | |  |  | | |  |  | |  | |  | | City: |  | | | State: |  | | Zip: | |  |  |  |  |  |  | | --- | --- | --- | --- | | Home Phone: | (     )     - | Work Phone: | (     )     - | | | | | | |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | Employer's Name: | | |  | | | | | |  | | |  | | | | | | Address: | |  | | | | | | |  |  | | |  |  |  |  | | City: |  | | | State: |  | Zip: |  |  |  |  |  |  | | --- | --- | --- | --- | | Insurance Carrier: |  |  |  | | | |
| Preparer’s Name: |  | Law Firm: | |  | | Preparer’s Phone #: | (     )     - |
|  |  |  | |  | |  |  |

**A claim for workers’ compensation death benefits is made based on the following grounds:**

|  |  |  |  |  |  |  |  |  |  |
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|  | The Claimant is | |  | | (relationship to employee) | | of |  | (employee’s name) |
| 1. | | The employee sustained an accidental injury to the       (Part of Body Hurt) on       (Month Day Year) in       County, State of      . | | | | | | | |
| 2. | | Both the employee and the employer were subject to the South Carolina Workers’ Compensation Act at the time of injury. | | | | | | | |
| 3. | | The relationship of employer and employee existed at the time of injury. | | | | | | | |
| 4. | | At the time of the injury the employee was performing services arising out of and in the course of employment. | | | | | | | |
| 5. | | Notice of the accidental injury was given to the employer on       (Month Day Year) in the following manner: | | | | | | | |
| 6. | | Due to injury, the employee received medical examination and treatment which remains unpaid by the employer. | | | | | | | |
| 7. | | Due to injury, the employee lost compensable time from work and wages for the periods of: | | | | | | | |
| 8. | | The employee died on | |  | | (Month Day Year) as a result of the accidental injury, and death | | | |
|  | | compensation is claimed. | | | | | | | |
| 9. | | At the time of the injury, the employee was paid weekly wages of $     . The claimant demands an accounting of days worked and wages earned as provided by law. | | | | | | | |
| 10. | | Further grounds of claim: | | | | | | | |
| 11. | | Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers’ Compensation Commission may direct as just and proper. | | | | | | | |
| 12a. | | **I am filing a claim. I am not requesting a hearing at this time.** | | | | | | | |
| 12b. | | **I am requesting a hearing. A $50 fee is required.** | | | | | | | |

**Mediation**

a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.

b. Mediation is required pursuant to Reg. 67-1802.

c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.

d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

Questions regarding mediation may be submitted to [**mediation@wcc.sc.gov**](mailto:mediation@wcc.sc.gov).

**I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on the \_\_\_day of \_\_\_\_20\_\_,by  first class postage  certified mail  personal service.**

**I verify the contents of this form are accurate and true to the best of my knowledge.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preparer’s Signature Title Email Date

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| --- | --- | --- | --- |
| Questions about the use of this form should be directed to the Judicial Department at 803.757.5675 or [**judicial@wcc.sc.gov**](mailto:judicial@wcc.sc.gov) or [**mediation@wcc.sc.gov**](mailto:mediation@wcc.sc.gov)**.** Refer to Regulations 67-205 through 67-211, 67-216, Regulations 67-601 through 67-615 and; Regulations 67-901 through 67-905 well as Reg. 67-1801.   |  |  |  | | --- | --- | --- | | **WCC Form # 52**  Revised 7/18 | 52 | Employee’s Notice of Claim and/or  Request for Hearing, Death Case | |