Amended/Corrected

South Carolina Workers' Compensation Commission 1333 Main Street, Suite 500 • Post Office Box 1715 Columbia, South Carolina 29202-1715
(803) 737-5700 www.wcc.sc.gov

WCC File #: _____
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Decedent's Name: _____ SSN: ___ - ___ - ____
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 Notification of fatality and/ or a claim for workers' compensation death benefits is made based on the following grounds:

1. Name of Deceased Employee: _____.
2. Name of survivor claiming he or she is entitled to death benefits (**the Claimant**): _____.
3. **Claimant asserts he or she is:** ☐ Surviving Spouse; ☐ Minor Child; ☐ Other whole dependent; ☐ Partial dependent; ☐ Non-dependent adult child; ☐ Non-dependent Father or Mother; or ☐ Requesting benefits under § 42-9-140(D) or (E) only
4. The employee sustained an accidental injury to the _____ (Part of Body Hurt) on _____ (Month Day Year) in _____ County, State of _____.
5. Both the employee and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.
6. The relationship of employer and employee existed at the time of injury.
7. At the time of the injury the employee was performing services arising out of and in the course of employment.
8. Notice of the accidental injury was given to the employer on _____ (Month Day Year) in the following manner:

_____

☐ 9. Due to injury, the employee received medical examination and treatment which remains unpaid by the employer.

☐ 10. Due to injury, the employee lost compensable time from work and wages for the periods of:

11. The employee died on _____ (Month Day Year)
    - ☐ a) as a result of the accidental injury, and death compensation is claimed under § 42-9-290; or
    - ☐ b) from a cause unrelated to the injury, and compensation is being claimed under § 42-9-280.

☐ 12. At the time of the injury, the employee was paid weekly wages of $_____.

☐ 13. Further grounds of claim: _____

☐ 14. 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.

☐ 15. I am adding a party. _____(name/address).
I am removing a party. _____(name/address).
Other amendment: _____.

☐ 16. **I am filing a claim. I am not requesting a hearing at this time.**

☐ 17. **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 the consent of the Parties pursuant to Reg. 67-1803. ☐d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

I certify I have served this document pursuant to Reg. 67-211. See attached certificate of service. I verify the contents of this form are accurate and true to the best of my knowledge.

Preparer's Signature	Title	Email	Date
_____	_____	_____	_____