ALASKA DEPARTMENT OF LABOR &
WORKFORCE DEVELOPMENT
Alaska Workers' Compensation Board
P.O. Box 115512, Juneau AK 99811-5512

DEATH BENEFITS REPORT

AWCB Case Number:

Complete this form and attach to Compensation Report (Form 07-6104) when you begin, change, suspend or terminate death benefits payments.

1. Deceased Employee's Name (Last, First, Middle Initial)	2. Insurer Claim Number	3. Date of Injury
4. Date of Death		5. Social Security Number
6. Place of Death		7. Date of Birth
8. Employer	9. Insurer	
10. Address	11. Address	
City State Zip Code Telephone	City State Zip Code Telephone	

12. WIDOW(ER) AND/OR CHILDREN:

a. Name (Last, First Middle Initial)	Date of Birth	Weekly Rate	Date Benefits Terminated
Address	City	State	Zip Code
b. Name (Last, First Middle Initial)	Date of Birth	Weekly Rate	Date Benefits Terminated
Address	City	State	Zip Code
c. Name (Last, First Middle Initial)	Date of Birth	Weekly Rate	Date Benefits Terminated
Address	City	State	Zip Code
d. Name (Last, First Middle Initial)	Date of Birth	Weekly Rate	Date Benefits Terminated
Address	City	State	Zip Code
e. Name (Last, First Middle Initial)	Date of Birth	Weekly Rate	Date Benefits Terminated
Address	City	State	Zip Code

13. DEPENDENT PARENTS, GRANDCHILDREN, BROTHER(S) AND/OR SISTER(S):

a. Name (Last, First Middle Initial)	Date of Birth	Weekly Rate	Date Benefits Terminated
Address	City	State	Zip Code
b. Name (Last, First Middle Initial)	Date of Birth	Weekly Rate	Date Benefits Terminated
Address	City	State	Zip Code
c. Name (Last, First Middle Initial)	Date of Birth	Weekly Rate	Date Benefits Terminated
Address	City	State	Zip Code

This is to certify that the original Death Benefits Report and the Compensation Report (Form 07-6104) have been mailed to all dependents at the above address(es), and copies have been mailed to the Alaska Workers' Compensation Board.

14. Name and Title of Person Submitting Report (Print or Type)	15. Signature	16. Report Date
17. Address	City State Zip Code	Telephone