EMPLOYER
ADDRESS 1
ADDRESS 2
CITY STATE ZIP

CLAIMANT
ADDRESS 1
ADDRESS 2
CITY STATE ZIP

WC CLAIM NO: 2011-017964
INJURY DATE: 06/21/11
EMPLOYEE: GARFIELD, JAMES
EMPLOYER: EMPLOYER NAME
INSURER NO:

IF YOU CALL OR WRITE US
PLEASE USE WC CLAIM NO.

Circumstances of this fatality were investigated by a safety specialist of the Department of Commerce. The investigation indicates that the fatality was caused by your failure to comply with Safety Order No. Ind. [FILL IN}. If correct, you are responsible for an additional 15 percent of the death benefit. A copy of the safety specialist's report is enclosed.

If you dispute the findings of this investigation, please inform us immediately. The matter will then be scheduled for hearing.

Unless we hear from you within 30 days, we shall assume that you have accepted liability and that you will pay 15 percent of the death benefits as applied on all payments of primary benefits. You should contact your insurance carrier for information regarding the amount of the primary death benefit payable and the name and address of the dependent to whom it is being paid. When the first payment of 15 percent increased benefits has been made, please furnish us with a receipt for our records. A final receipt will be required when the last payment has been made. The total increased benefits cannot exceed $15,000.00.

Department of Workforce Development
Worker's Compensation Division

GL23 (R. 02/1998)

Enc.

Copy sent to:
INSURER
ADDRESS 1
ADDRESS 2
CITY STATE ZIP