State of New York
WORKERS' COMPENSATION BOARD
SELF-INSURER'S STATEMENT OF OUTSTANDING DEATH CLAIMS

Name of Self-Insurer: _____

PLEASE TYPE

W.C.B. Case Number	Name of Deceased (Last Name, First Initial)	Date of Death	Date of Accident if Different	Average Weekly Wage at Time of Accident	**For Board Use Only**	Dependents				**For Board Use Only**	
						Given Name	Relationship	Year of Birth	Weekly Comp Rate		

I hereby affirm under penalty that I have examined this report, and to the best of my knowledge and belief, it is true, correct and complete.

_____ **Signature of Company Officer**

_____ Title

_____ Telephone No.

_____ Date Signed

_____ Printed or Typed Name

_____ Address (No., Street, City, State, and Zip Code)

(If more than one page is needed, complete affirmation on top page only.)

SI-4 (9/15)

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SI-4 (9/15) Reverse