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| **South Carolina Workers’ Compensation Commission**1333 Main Street, Suite 500 ● Post Office Box 1715Columbia, South Carolina 29202-1715(803) 737-5723 [www.wcc.sc.gov](http://www.wcc.sc.gov)  | SCSealBWjpg |

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| WCC File #: |  |
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| Carrier File #: |  |
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| Carrier Code #: |  |
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| Employer FEIN #: |  |
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| --- | --- | --- | --- |
| Claimant's Name: |       | SSN: |    -  -     |
|  |  |
| Address: |       |
|  |  |  |  |  |  |
| City: |       | State: |    | Zip: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Home Phone: | (     )     -      | Work Phone: | (     )     -      |

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|  |  |
| --- | --- |
| Employer's Name: |       |
|  |  |
| Address: |       |
|  |  |  |  |  |  |
| City: |       | State: |    | Zip: |       |

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| --- | --- | --- | --- |
| Insurance Carrier: |       |  |  |

  |
|  Preparer’s Name: |       |  Law Firm: |       |  Preparer’s Phone #:  | (     )     -      |
|  |  |  |  |  |  |

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

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | 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 $25 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**.

**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

|  |  |  |  |
| --- | --- | --- | --- |
| Questions about the use of this form should be directed to the Judicial Department at 803.757.5675 or **judicial@wcc.sc.gov** or **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.

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| **WCC Form # 52**Revised 7/13 | 52 | Employee’s Notice of Claim and/or Request for Hearing, Death Case |

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