SUPPLEMENTAL REPORT OF FATAL INJURY

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P.O. Box 30016, Lansing, MI 48909

THIS REPORT IS TO BE FILED BY THE EMPLOYER IMMEDIATELY AFTER THE DEATH OF AN INJURED EMPLOYEE.

I. DECEASED EMPLOYEE

1. SOCIAL SECURITY NUMBER	2. DATE OF INJURY	3. DATE OF DEATH	
4. NAME (Last, First, Middle Initial)			
5. STREET ADDRESS	6. CITY	7. STATE	8. ZIP CODE

II. EMPLOYER DATA

9. EMPLOYER NAME		10. FEDERAL I.D. NUMBER	
11. STREET ADDRESS	12. CITY	13. STATE	14. ZIP CODE
15. AMOUNT OF BURIAL EXPENSES PAID (If Not Previously Reported) $			

III. DEPENDENTS OF EMPLOYEE

16. NAME	17. DATE OF BIRTH	18. RELATIONSHIP TO DECEASED (Spouse, Child, or Other) (Please Specify Other)	19. EXTENT OF DEPENDENCY (Total/Partial)

20. EMPLOYER'S SIGNATURE	21. TITLE	22. DATE

Authority: Workers' Disability Compensation Act, R 408.31(3)
Completion: Mandatory
Penalty: Workers' Disability Compensation Act 418.631