Texas Department Of Insurance

Division of Workers' Compensation
Records Processing
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Austin, TX 78744-1609
(800) 252-7031 (512) 804-4378 fax www.tdi.state.tx.us

DWC Claim#
Carrier Claim#

← Send the completed form to this address.

Notice of Fatal Injury or Occupational Disease and Claim for Compensation for Death Benefits (DWC Form-042)

● Beneficiaries of an employee who died from an on-the-job injury or occupational disease must file this form with the Texas Department of Insurance, Division of Workers' Compensation (Division) **no later than one year** after the employee's death to protect your claim for entitlement to death benefits.
● If you do not know the answer to a question on this form, please reply "unknown."

I. DECEASED EMPLOYEE INFORMATION

Name (First, Middle, Last)	**Social Security Number**	**Date of birth** (mm / dd / yyyy)
Address at time of death (street, city/town, state, zip code, county, country)		

Race / Ethnicity ☐ White, not of Hispanic Origin ☐ Black, not of Hispanic Origin ☐ Hispanic ☐ Asian or Pacific Islander

Did the employee speak English? ☐ Yes ☐ No If no, specify language

Marital status ☐ Married ☐ Widowed ☐Separated ☐Single ☐Divorced **Sex** ☐Male ☐Female

II. INJURY INFORMATION

Death occurred as a result of an ☐ injury ☐ occupational disease	**Date of injury** (mm / dd / yyyy)	**First work day missed** (mm / dd / yyyy)

Date of Hire (mm / dd / yyyy)	**Occupation at time of injury**
Time of injury	**Body part affected**

Describe cause of injury or occupational disease, including how it is work related

Witness(es) to the injury

If accident occurred outside of Texas, on what date did the employee leave Texas? (mm/dd/yyyy)

Where injury/accident occurred **County** **State** **Country**

Date of death (mm/dd/yyyy)	**Cause of death**

If death was the result of an occupational disease:
1. On what date was the employee last exposed to the cause of the occupational disease? (mm / dd / yyyy)
2. Explain how the disease was related to the employment.

III. EMPLOYER INFORMATION (at the time of the injury)

Employer name	**Employer address** (street, city/town, state, zip code, county, country)
Employer phone number	**Supervisor name** (First, Last)

IV. DOCTOR INFORMATION

Name of treating doctor	**Phone number**
Address (street, city/town, state, zip code)	

Before completing this page, please read the section of the instructions titled ELIGIBLE BENEFICIARIES.

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V. INFORMATION ABOUT PERSON FILLING OUT THIS FORM

Full name	Date of birth (mm / dd / yyyy)	Social Security Number
Mailing address (street, city/town, state, zip code)		
Phone number	Are you an eligible beneficiary? ☐Yes ☐No	
Relationship to deceased		

If you are an eligible, non-dependent parent, please check the appropriate box:

- ☐ Burial benefits have been received from the insurance carrier (attach proof that you received burial benefits.)
- ☐ Claim for burial benefits filed at the same time as the claim for death benefits.
- ☐ Claim for burial benefits pending with insurance carrier.

VI. ARE YOU FILING THIS CLAIM ON BEHALF OF OTHER BENEFICIARIES? ☐Yes ☐No

A claim by an eligible non-dependent parent must designate all eligible parents and necessary information for payment to the eligible parents.

Beneficiary full name		Social Security Number
Mailing address (street, city/town, state, zip code)		
Phone number	E-mail address	Full-time student ☐ Yes ☐No
Date of birth (mm / dd / yyyy)		Relationship to deceased
If beneficiary is a minor, who may be contacted on their behalf? (parent, legal guardian)		
Parent/legal guardian's contact information (phone, address, email, etc.)		

Beneficiary full name		Social Security Number
Mailing address (street, city/town, state, zip code)		
Phone number	E-mail address	Full-time student ☐ Yes ☐No
Date of birth (mm / dd / yyyy)		Relationship to deceased
If beneficiary is a minor, who may be contacted on their behalf? (parent, legal guardian)		
Parent/legal guardian's contact information (phone, address, email, etc.)		

Beneficiary full name		Social Security Number
Mailing address (street, city/town, state, zip code)		
Phone number	E-mail address	Full-time student ☐ Yes ☐No
Date of birth (mm / dd / yyyy)		Relationship to deceased
If beneficiary is a minor, who may be contacted on their behalf? (parent, legal guardian)		
Parent/legal guardian's contact information (phone, address, email, etc.)		

VII. ARE YOU AWARE OF ANY OTHER BENEFICIARY(IES)? (please attach additional pages, if needed)

Beneficiary full name	Relationship to the deceased
Address	Phone number
Beneficiary full name	Relationship to the deceased
Address	Phone number
Beneficiary full name	Relationship to the deceased
Address	Phone number

Signature of beneficiary or person completing this form on behalf of beneficiary

Date

Instructions for Completing the
Notice of Fatal Injury or Occupational Disease and
Claim for Compensation for Death Benefits (DWC Form-042)

Eligible beneficiaries have *one year* after the date of the employee's death to file this form with the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) to claim death benefits UNLESS:

1. the person is a minor or incompetent;
2. a beneficiary other than an eligible, non-dependent parent, has good cause for the failure to file a claim; or
3. an eligible non-dependent parent submits proof satisfactory to the commissioner of a compelling reason for the delay.

Eligible Beneficiaries

Each person must file a separate claim for death benefits unless the claim expressly includes or is made on behalf of another person (for example, a spouse filing a claim that includes dependent children, or eligible non-dependent parent). Please attach a copy of the death certificate and copies of any marriage certificate(s), divorce decree(s), birth certificate(s), or other documentation that may assist in establishing the eligibility of beneficiaries to expedite the processing of this claim. A claim by an eligible non-dependent parent must designate all eligible parents and necessary information for payment to the eligible parents.

A complete description of eligible beneficiaries may be found in 28 Texas Administrative Code, Chapter 132 Death Benefits--Death and Burial Benefits. If you have questions about your eligibility as a beneficiary, please consult the rule, your attorney or the adjustor. Eligible beneficiaries may include:

- the deceased employee's spouse
- the deceased employee's child (may include minor children, children who are full-time students younger than 25, or stepchildren or other dependent minor family members)
- deceased employee's dependent grandchild if the grandchild's parent is not an eligible child

If there is no eligible spouse, child, or grandchild, death benefits shall be paid in equal shares to surviving dependents of the deceased employee who are parents, stepparents, siblings or grandparents of the deceased.

If there is no eligible spouse, no eligible child, and no eligible grandchild, and there are no surviving dependents of the deceased employee who are parents, siblings, or grandparents of the deceased, the death benefits shall be paid in equal shares to surviving eligible parents of the deceased. "Eligible parent" means the mother or the father of a deceased employee, including an adoptive parent or a stepparent, who receives burial benefits under Section 408.186. The term does not include a parent whose parental rights have been terminated.

Burial Benefits

A person claiming burial benefits must file a request for reimbursement or payment with the carrier and attach the bills showing funeral expenses and transportation costs, if any. The request for burial benefits must be sent to the insurance carrier within 12 months of the employee's death. The maximum burial benefit payable is $6000.00.

Contacting Texas Department of Insurance, Division of Workers' Compensation

If you have questions about filling out this form or other claim-related questions, please call your local TDI-DWC Field Office at 1-800-252-7031.

NOTE: With few exceptions, you are entitled on request to be informed about the information that TDI-DWC collects about you. Under §§552.021 and 552.023 of the Government Code, you are entitled to receive and review the information. Under §559.004 of the Government Code you are entitled to have TDI-DWC correct information about you that is incorrect. For more information, call the local TDI-DWC field office at 800-252-7031.