Reset Form | Print Form

DHR-ESB3019
11/03

DEATH CLAIM NOTICE

The report should include a copy of the I.C. Form 19
Note: Complete all sections of this report

Received: _____ Date: _____
Agency Name: _____ Form completed by:
Division: _____ _____
Name and Phone Number
Address: _____
_____

Date of Accident: _____ Date of Death _____
Claimant Name: _____ Claimant Age _____
Job: Title: _____
Working Title: _____

Surviving Spouse or Nearest Relative: (Current Mailing Address)
Relationship: _____
Name: _____
Address: _____
Telephone#: Home: _____ Work _____
Children's Names: _____
_____

Describe the accident in detail: _____
_____

Cause of Death: _____

Other Pertinent Information:
Length of Employment: _____
Date of Employment: _____
Estimated Death Claim Benefits: _____

STATE EMPLOYEE MEMORIAL PROGRAM
PLEASE PROVIDE INFORMATION FOR MEMORIAL AS SOON AS POSSIBLE

Provide employee's name as desired to appear on certificate:
_____

Request flag flown at State Capitol (Dated Certificate) Yes _____ No _____

Date Flag(s) Needed: _____ U.S. Flag _____ &/or _____ N.C. Flag
Funeral Arrangements: _____
_____

NOTIFY RISK CONTROL SERVICES (919-733-6316 AND FAX 919-715-9750) OF EMPLOYEE FATALITY WITHIN 8 HOURS OF KNOWLEDGE OF DEATH OR NEXT WORKDAY.