FORM 20

Send original to
Workers' Compensation Court and 1 copy to
All Other Parties of Record

WORKERS' COMPENSATION COURT
1915 NORTH STILES
OKLAHOMA CITY, OKLAHOMA 73105-4918

THIS SPACE FOR COURT USE ONLY

IN THE MATTER OF THE DEATH OF

Name of deceased employee
Name of person filing Proof of Loss
Name of Employer or Respondent
Employer's Insurance Carrier, Permit # for Court Approved Individual Self-Insured or Own Risk Group, Uninsured

PROOF OF LOSS FOR SPOUSE AND CHILDREN
(Lump Sum Benefits)

FILE NO.
Deceased Employee's Social Security Number

STATE OF OKLAHOMA)
) SS.
COUNTY OF _____) (PLEASE TYPE OR PRINT)

_____, of lawful age, being first duly sworn on oath, alleges and states:

That affiant is the _____ (relation to decedent) and _____

That on the _____ day of _____, _____ , the decedent, _____ (relation to children) sustained an accidental personal injury arising out of and while in the course of employment and died as a result of said injuries on the _____ day of _____, _____.

Affiant states that at the time of death, decedent was lawfully married to _____ residing at _____, and left surviving the following named children:

NAME (List additional children on back of form)	DATE OF BIRTH	ADDRESS
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Affiant further declares under penalty of perjury that affiant has examined this proof of loss and the statements contained herein, and to affiant's best knowledge and belief they are true, correct and complete. Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

Affiant hereby certifies that copies of necessary marriage, birth and death certificates were mailed to the opposing party/counsel on _____. ***NOTE: Certified copies of these documents shall be offered at the time of trial.***

Signed this_____day of_____,_____

_____
Signature of person completing the Proof of Loss

I HEREBY CERTIFY THAT A COPY HAS BEEN SENT TO:

Opposing Party
Address (Number and Street)
City State Zip Code

Name of claimant's attorney, if represented OBA #
Address of Attorney
City State Zip Code
Telephone #

2/06

_____
Signature of Claimant's Attorney OBA #