Reset

Department of Labor and Industry Workers' Compensation Division 651-284-5032 or 800-342-5354

Notice of Discontinuance of Workers' Compensation Benefits Upon Death of Employee

BD02

Print in ink or type
Enter dates in MM/DD/YYYY format

DO NOT USE THIS SPACE

WID number or SSN	Date of injury (DOI)	Date of death
Employee (last, first, middle initial)	Employer	
Employee address		
City	State	ZIP code
Insurer claim number		

Notes

Reasonable medical expense related to the injury will still be paid.
Insurer must complete the following.

Due to the employee's death, workers' compensation wage-loss benefits were discontinued on _____ (date).

1. Was the employee's death related to the work injury? ☐ Yes ☐ No ☐ Unknown

   If yes, the insurer must contact the heirs or dependents as soon as possible and file a First Report of Injury (related to the death) with the Workers' Compensation Division.

2. Will any permanent partial disability benefits the employee was receiving at the time of death continue to be paid to the heirs or dependents?

   ☐ Yes, for how long? _____

   ☐ No, why not? _____

Information for heirs and dependents regarding discontinuance

- You may make a claim for benefits by notifying the employer or the workers' compensation insurer claim representative in writing that you believe the death was related to the injury and are claiming workers' compensation benefits.
- If you have questions about the benefits paid or owed to the deceased employee, continuing permanent partial disability benefits or dependency benefits, call the insurer claim representative at the telephone number listed at the end of this form.
- If you still have questions, contact the Workers' Compensation Division office nearest you.

525 Lake Ave. S., Suite 330
Duluth, MN 55802
(218) 733-7810 or 1-800-342-5354

443 Lafayette Road N.
St. Paul, MN 55155
(651) 284-5032 or 1-800-342-5354

Average weekly wage at DOI $	**Include contingent attorney fees in benefit totals**				
The following benefits have been paid	**From**	**Through**	**Weeks**	**Rate**	**Total**
☐ Temporary total disability or ☐ Permanent total disability ☐ Benefit addendum attached					
Temporary partial disability					
Retraining benefits					
Permanent partial disability _____% ☐ Injuries on or after 10/01/95 ☐ Impairment compensation (injuries 01/01/1984 through 09/30/1995) ☐ Economic recovery compensation (injuries 01/01/1984 through 9/30/1995) ☐ Part of body (injuries before 01/01/1984) _____					

Attorney fees/expenses		**Benefit totals**	
M.S. § 176.081, subd. 1, contingent fees paid		Lump-sum payment under award or order (include contingent attorney fees)	
M.S. § 176.081, subd. 1, contingent fees still withheld		Attorney fees reimbursed to employee (M.S. § 176.081, subd. 7)	
Heaton fees paid		Interest paid	
Roraff fees paid		**Total compensation paid** (include contingent attorney fees)	
M.S. § 176.191 fees paid		Total supplementary benefits (include contingent attorney fees)	
Other fees paid		Total medical expenses paid to date	
Costs and disbursements paid			

Insurer/self-insurer/TPA			Claim representative name	
Address			Phone number (include area code)	Extension
City	State	ZIP code	Date sent to employee's last known address	Date served on employee's attorney (if any)

This document can be given to you in Braille, large print or audio. To request, call (651) 284-5032 or 1-800-342-5354.

Any person who, with intent to defraud, receives workers' compensation benefits to which the person is not entitled by knowingly misrepresenting, misstating or failing to disclose any material fact is guilty of theft and shall be sentenced pursuant to Minnesota Statutes § 609.52, subdivision 3.

Send to: Workers' Compensation Division, employer, employee, insurer, heirs and dependents, and the employee's attorney (if any).