COMPLAINT

UNDER THE

IRONWORKERS COLLECTIVELY BARGAINED WORKERS' COMPENSATION PROGRAM

(DEATH CASE ONLY)

Case No. _____

_____ (Deceased Employee's Name & Social Security No.)

_____ (Employer's Name)

_____ (Street Address)

_____ (Street Address)

_____ (City, State & Zip Code)

_____ (City, State & Zip Code)

_____ (Applicant's Name)

_____ (Street Address)

_____ (City, State & Zip Code)

1. While employed as a _____ (occupation at time of injury) on _____ (date of injury) at _____ (name and location of job site) by the employer, the employee sustained injury arising out of and in the course of employment to _____ (state what parts of the body were injured)

2. The injury occurred as follows: _____ (explain what employee was doing at the time of injury and how injury occurred), resulting in death on _____ (date of death)

3. The employee left the following dependents:

Name	Date of Birth	Relationship	Address

Employee requests: Death Benefit _____ Burial Expense _____ Unpaid Compensation _____ Unpaid Medical Expenses_____

Other (Explain):_____

_____ (Date)

_____ (Employee's Signature, or Attorney's if represented)

Must be timely filed with the ADR Ombudsman:
Eric J. Nobriga Sr.
Ironworkers Collectively Bargained Workers Compensation Program
2120 Foothill Blvd., Suite 100
La Verne, CA 91750
Office: (626) 356-3051 or (888) 615-4766; Fax: (866) 322-2044