KANSAS DEPARTMENT OF LABOR
www.dol.ks.gov

SURVIVING SPOUSE, DEPENDENT OR HEIR APPLICATION FOR BENEFITS

K-WC E-2 Pro Se (Rev. 11-18) (K.S.A. 44-510b)

DO NOT WRITE IN THIS SPACE

Date Stamp

Deceased employee: _____
First *Middle* *Last*

Date of birth: _____

Social Security number: _____

Address at time of death: _____

City: _____ State: _____ ZIP: _____

Employer: _____

Address: _____

City: _____ State: _____ ZIP: _____

Insurance carrier: _____
(Required)

Accidental Injury, Repetitive Trauma or Occupational Disease

Date(s) of accident/repetitive trauma/occupational disease: _____ Time: ___:___ ☐ A.M. ☐ P.M. Date of death: _____

How did accident/repetitive trauma/disease occur? _____

_____

In what county did it occur? _____ At or near *(city)* _____ *(state)* _____

If it **did not** happen within Kansas, in which **Kansas** county could hearing be most conveniently held? _____

Surviving Spouse, Dependents or Heirs

Name	Address	Email	Date of Birth	Relationship

DO NOT USE THIS FORM IF YOU ARE AN ATTORNEY OR HAVE AN ATTORNEY

By completing this form and submitting it to the Division, you certify that you are not represented by an attorney for the matter referenced herein.

_____ *Applicant printed name*

_____ *Signature*

_____ *Date*

Address: _____

DO NOT WRITE IN THIS SPACE

Certified Stamp ALJ Copy

Federal Privacy Act Disclosure Section 7(a)(2)(B)

The mandatory requirement that Social Security numbers be included on forms filed with the Division of Workers Compensation is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, since our regulations which require its disclosure were in existence before January 1, 1975. The number is used as a means of identifying all the various records in the Division of Workers Compensation pertaining to an individual.

The use of Social Security numbers is made necessary because of the large number of applicants who have similar names and birth dates, and whose identities can only be distinguished by the Social Security number.