State of Connecticut Workers' Compensation Commission

This form prepared by the WCC is proper for ordinary use and is recommended, but any other notice complying with Section 31-294c shall be deemed sufficient.

To be filed by dependent of deceased employee, or legal representative of such dependent, following the work-related death of employee. ATTACH DEATH CERTIFICATE, if available.

Rev. 01-31-2018

30D

WCC File #

Date filed in District

(for WCC use only)

Dependent's Notice of Claim

(To Commissioner and to Employer)

Notice is hereby given that the injured worker, while in the employ of the employer, sustained injuries arising out of and in the course of his/her employment and died as a result of such work-related injury or illness in the manner described below.

His/her dependent makes claim for compensation benefits pursuant to Sec. 31-306 C.G.S.

Please TYPE or PRINT IN INK

DEPENDENT

Name _____

D.O.B. _____

Check, if a Minor ☐ *(under 18 yrs. of age)*

Relationship to deceased employee _____

Address _____

Town _____ State _____

Zip Code _____ Tel.# _____

DECEASED'S INJURY

Date of Injury _____

Date of Death _____

Town of Injury _____

Describe employee's Injury/Illness and its relationship to cause of death:

☐ Check, if an Occupational Disease or a Repetitive Trauma

☐ Check, if decedent had MORE THAN ONE Employer on Date of Injury

DECEASED EMPLOYEE

Name _____

D.O.B. *(required)* _____

DECEASED'S EMPLOYER

Employer _____

Address _____

Town _____ State _____

Zip Code _____ Tel.# _____

SIGNATURE OF DEPENDENT OR REPRESENTATIVE

Signature _____

Date _____

Print name & address below, if other than dependent:

Name _____

Name of Firm _____

Address _____

Town _____ State _____

Zip Code _____ Tel.# _____

This notice must be served upon the Commissioner and *Employer by personal presentation or by registered or certified mail. For the protection of both parties, the employer should note the date when this notice was received and the claimant should keep a copy of this notice with the date it was served.

* *Dependents of persons employed by the State of Connecticut must serve the employer by serving this notice upon the Commissioner of Administrative Services, 450 Columbus Boulevard, Hartford, CT 06103.*

* *Dependents of persons employed by a municipality must serve the employer by serving this notice upon the town clerk of the municipality in which the employee was employed.*

* *Dependents of persons employed by an employer who pursuant to statute has posted the location where this notice is to be filed have an obligation to file it at that location, using certified mail.*

WARNING: If an employer does not file a notice contesting liability (e.g. Form 43) for this claim OR begin making workers' compensation benefit payments "without prejudice" within 28 calendar days from the date when this claim is received by personal delivery or by registered or certified mail, COMPENSABILITY SHALL BE PRESUMED and cannot thereafter be contested. If an employer chooses to begin making workers' compensation benefit payments "without prejudice" within 28 calendar days from the date of receipt of this claim and still wishes to contest this claim, it must do so by filing a notice contesting liability for this claim within one year from receipt of this claim. [See Sec. 31-294c(b).]

There is a statute of limitations for filing a workers' compensation claim for death benefits. If death results within two years from the date of the accident or first manifestation of a symptom of the occupational disease, a claim may be made within the two year period, or within one year from the date of death, whichever is later. (Sec. 31-294c)

Directions for Completing the 30D Claim Form

1. In the box marked "**DEPENDENT**" – type or neatly print the name, date of birth, and address of the dependent who is filing the claim on behalf of the deceased worker. Remember to check the box, if the dependent is a minor (under the age of 18). **Identify the dependent's relationship to the deceased worker.**

2. In the box marked "**DECEASED EMPLOYEE**" – **type or neatly print the name of the deceased worker.** Also fill in the deceased worker's date of birth.

3. In the box marked "**DECEASED'S EMPLOYER**" – **type or neatly print the name of the deceased worker's employer.** (*This means the name of the organization the decedent worked for, not the boss or supervisor.)*

4. In the "**DECEASED's INJURY**" box – **type or neatly print the date of the deceased worker's injury, or the date of the 1st manifestation of their occupational illness.**

   Type the date of death and the town in which the injury actually took place. *(Note: This will not necessarily be the same location as the employer's business address.)*

   Briefly describe the employee's injury/illness and explain how it was related to their death.
   Also:
   Check the box if the employee died from an Occupational Disease, or a Repetitive Trauma.

   Check the box if the employee worked for MORE THAN ONE employer on the Date of Injury.

5. In the "**SIGNATURE OF DEPENDENT OR REPRESENTATIVE**" box – sign your name and fill in the date of your signature.

   If you are NOT the dependent for whom benefits are being claimed, then sign your name, and fill in the date of your signature. Then print your name and the name (if any) of your firm, as well as the address and telephone number.

Directions for Filing the 30D Claim Form

1. **Make two (2) extra copies of the completed 30D Form**.

2. **Send the original 30D to the deceased worker's employer** by Certified or Registered mail, requesting a return receipt. The claim may also be delivered in person if the employer acknowledges receipt of the claim in writing.

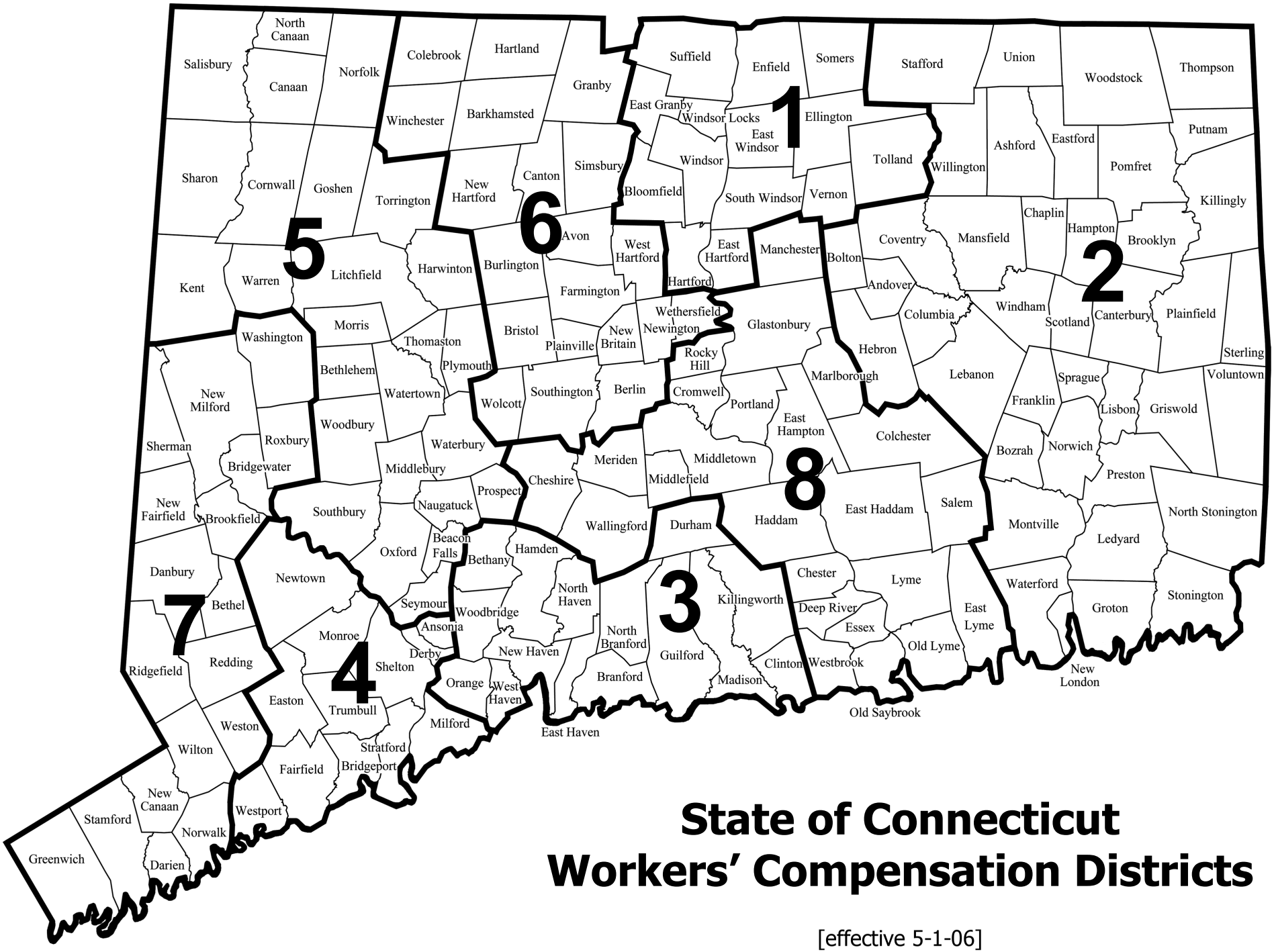
   A 30D Form filed on behalf of a dependent of a State employee must be delivered to the Commissioner of Administrative Services, 450 Columbus Boulevard, Hartford, CT 06103 and NOT to the particular office where the deceased worker was employed.

   A 30D Form filed on behalf of a dependent of a Municipal employee must be delivered to the town clerk of the municipality in which the deceased worker was employed.

   A 30D Form filed on behalf of a dependent of an employee (other than a State or municipal employee), who pursuant to statute has posted the location where claims for compensation are to be filed, must be filed at that location, by certified mail.

3. **Send a copy of the 30D to the appropriate Workers' Compensation Commission District Office** by Certified or Registered mail, requesting a return receipt, or deliver in person. The District Office is determined by the town in which the deceased employee was injured or in which they suffered their occupational illness. Refer to the Connecticut map provided with this form for the number and address of the appropriate Compensation District.

4. **Keep the remaining copy of the 30D for your own file**.



State of Connecticut
Workers' Compensation Districts

[effective 5-1-06]

Workers' Compensation Commission District Offices

District 1 — Hartford

999 Asylum Avenue
Hartford, CT 06105

Phone: (860) 566-4154
Fax: (860) 566-6137

District 2 — Norwich

55 Main Street
Norwich, CT 06360

Phone: (860) 823-3900
Fax: (860) 823-1725

District 3 — New Haven

700 State Street
New Haven, CT 06511-6500

Phone: (203) 789-7512
Fax: (203) 789-7168

District 4 — Bridgeport

350 Fairfield Avenue
Bridgeport, CT 06604

Phone: (203) 382-5600
Fax: (203) 335-8760

District 5 — Waterbury

55 West Main Street
Waterbury, CT 06702

Phone: (203) 596-4207
Fax: (203) 805-6501

District 6 — New Britain

24 Washington Street
New Britain, CT 06051

Phone: (860) 827-7180
Fax: (860) 827-7913

District 7 — Stamford

111 High Ridge Road
Stamford, CT 06905

Phone: (203) 325-3881
Fax: (203) 967-7264

District 8 — Middletown

90 Court Street
Middletown, CT 06457

Phone: (860) 344-7453
Fax: (860) 344-7487