A Confidential Informational Form Letter for a BENEFICIARY who is NOT *Represented by Counsel*

To: P & O Department
Virginia Workers' Compensation Commission

Name of Beneficiary(ies)_____ Name of Employee: _____
Re: VWC File No._____:

I submit the following information in order to assist the Virginia Workers' Compensation Commission in determining whether to approve the proposed settlement of the deceased employee's workers' compensation claim.

I understand that this information will be sealed and held in confidence by the Commission.

1. Date and cause of death of employee: _____
2. Names and ages of all dependents:

Name	Age	Relationship to Employee, i.e., son, daughter, or spouse

3. Are you currently working? (yes or no) (circle one) If yes, please provide the following:

Employer	**Weekly Wages**

4. Please indicate the amount and source of any other income: (If you have no other income sources, please indicate "none" in the area below.)

Source	**Amount**

5. Are you able to read, write and understand the English language? (Yes or no) (Circle one).
(a) If you are not literate in English, state the name of the person reading, and/or translating, and explaining the settlement papers to you.

Name of Person	**Address**	**Telephone Number**

6. What is your intended use of the settlement proceeds?

(a) If you plan to pay any outstanding debts, please itemize your major debts (over $1000.00) and the amounts, and indicate which of these debts you plan to pay from the settlement.

Creditor	Amount Owed	Amount That You Plan to pay from the Proceeds

7. Have all medical and burial expenses relating to this claim been paid? Yes____ No_____ If not, indicate outstanding amount $_____

8. Please list all of your major financial assets (over $1000.00), including your home, land, bank accounts, certificates of deposits, stocks, bonds and any other type of investments.

Major Financial Asset	Value

9. Please explain, in your own words in the space provided below, why it is in your best interest to settle the claim in a lump sum in lieu of continuing benefits.

Please provide the following: (required)

Signature of Beneficiary:	Address:	Telephone Number: Date:

Please attach additional sheets to supplement your answers to any of the above questions.

Please return this completed form to:

Virginia Workers'Compensation Commission
1000 DMV Drive
Richmond, Virginia 23220