SURVIVORS' BENEFIT CLAIM - AMW/MONTHLY RATE VERIFICATION FORM

(FOR CLAIMS WITH DOI OR DATE OF DISABLEMENT BEFORE 7/1/19)

INSURER INFORMATION:	
Insurer Name:	
Nevada Certificate of Authority No.:	
NCCI Carrier Code (Private Carriers):	
Federal Employer Identification Number (FEIN):	

INJURED EMPLOYEE	
Injured Employee Last Name:	
Injured Employee First Name:	
Injured Employee SSN:	

CLAIM INFORMATION	
Date of Injury or Occ Disease Disablement:	
Claim Number:	
TPA (if applicable):	
Employer:	

CALCULATIONS		
Average Monthly Wage (AMW):		
Survivors' Monthly Rate (SMR):		
Date of Survivors' 1st Payment:		
Date of Survivors' Last Payment:		
Date of Injury or Occ Disease Disablement	New Rate	Catch Up Calculation
On or after 1/1/1994		No Catch Up
Between 1/1/1989 and 12/31/1993		SMR x 1.04653 (2.3% - 2X)
Before 1/1/1989		SMR x 1.07059 (2.3% - 3X)

SUPPORTING INFORMATION INCLUDED ('X' all that apply)	
D-5 (Wage Calculation Form)	
D-8 (Wage Verification Form)	
AMW Determination	
Survivors' Benefit Determination	
Decisions/Orders	
Other (Specify)	

OTHER INFO		
Annuity Purchased?		YES OR NO (Y OR N)
Multiple Survivors?		YES OR NO (Y OR N)

SUBMITTED BY:

Place an "X" in one box	TPA:	
	Insurer:	
	Other:	

Name:	
Title:	
Company:	
Email:	
Phone:	
Date:	