

**Claim for Benefits Under the Energy Employees
Occupational Illness Compensation Program Act**

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs



Note: Provide all information requested below. Do not write in the shaded areas. OMB Number: 1215-0197
Expiration Date: 08/31/2007

Employee Information (Please Print Clearly)

1. Name (Last, First, Middle Initial)	2. Social Security Number
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3. Date of Birth <table border="1" style="display:inline-table; margin-left:20px"> <tr> <td style="width:30px; height:20px;"></td> <td style="width:30px; height:20px;"></td> <td style="width:30px; height:20px;"></td> </tr> <tr> <td style="font-size:8px;">Month</td> <td style="font-size:8px;">Day</td> <td style="font-size:8px;">Year</td> </tr> </table>				Month	Day	Year	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	5. Dependents <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Other:
Month	Day	Year						

6. Address (Street, Apt. #, P.O. Box) (City, State, ZIP Code)	7. Telephone Number(s) a. Home: () - b. Other: () -
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8. Identify the Diagnosed Condition(s) Being Claimed as Work-Related (check box and list specific diagnosis)

<input type="checkbox"/> Cancer (List Specific Diagnosis Below)	9. Date of Diagnosis		
	Month	Day	Year
a.			
b.			
c.			
<input type="checkbox"/> Beryllium Sensitivity			
<input type="checkbox"/> Chronic Beryllium Disease (CBD)			
<input type="checkbox"/> Chronic Silicosis			
<input type="checkbox"/> Other Work-Related Condition(s) due to exposure to toxic substances or radiation (List Specific Diagnosis Below)			
a.			
b.			
c.			

Awards and Other Information

10. Did you work at a location designated as a Special Exposure Cohort (SEC)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
11. Have you filed a lawsuit seeking either money or medical coverage for the above claimed condition(s)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
12. Have you filed any workers' compensation claims in connection with the above claimed condition(s)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
13. Have you or another person received a settlement or other award in connection with a lawsuit or workers' compensation claim for the above claimed condition(s)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
14. Have you either pled guilty or been convicted of any charges connected with an application for or receipt of federal or state workers' compensation?	<input type="checkbox"/> YES <input type="checkbox"/> NO
15. Have you applied for an award under Section 5 of the Radiation Exposure Compensation Act (RECA)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, provide RECA Claim #: <input style="width:150px" type="text"/>	
16. Have you applied for an award under Section 4 of the Radiation Exposure Compensation Act (RECA)?	<input type="checkbox"/> YES <input type="checkbox"/> NO

Employee Declaration

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided under EEOICPA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both. Any change to the information provided on this form once it is submitted must be reported immediately to the district office responsible for the administration of the claim. I hereby make a claim for benefits under EEOICPA and affirm that the information I have provided on this form is true. If applicable, I authorize the Department of Justice to release any requested information, including information related to my RECA claim, to the U.S. Department of Labor, Office of Workers' Compensation Programs (OWCP). Furthermore, I authorize any physician or hospital (or any other person, institution, corporation, or government agency, including the Social Security Administration) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs.

Resource Center Date Stamp

_____ Employee Signature _____ Date

Instructions for Completing Form EE-1

Complete all items on the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. If the requested information is not submitted, the responsible party should explain the reason(s) for the delay and indicate when the information will be forthcoming. Submit the completed claim form and all other pertinent documentation to the appropriate district office administering the EEOICPA in the region where your most recent Energy employer is/was located.

Illness(es) Being Claimed

Item #8 – Identify the specific physician-diagnosed condition(s) that you claim are work related. Do not list the symptoms (e.g. aches, pains, cough, wheezing, breathing problems, etc.) associated with the diagnosed condition(s). If you require additional space, attach a signed supplemental statement to this form.

Item #9 – List the date a qualified physician first diagnosed the claimed condition(s).

Awards and Other Information

Item #10 – The EEOICPA allows for employees who have met particular criteria and have been employed at certain facilities to be designated as members of the Special Exposure Cohort (SEC). Indicate whether or not you worked at a location designated as an SEC.

Item #11- Indicate whether you have filed a civil lawsuit in regard to your claimed condition(s). If you mark YES, provide copies of all court documentation.

Item #12 - Indicate whether you have filed any workers' compensation claims in connection with the claimed condition(s). If you mark YES, provide copies of all workers' compensation documentation.

Item #13 – Indicate whether you or another person received a settlement or other type award from a workers' compensation claim or a lawsuit in connection with the claimed condition(s)? If YES, provide copies of all pertinent documentation.

Item #14 - Mark the appropriate box indicating whether or not you have ever pled guilty or been convicted of any charges connected to an application for or receipt of federal or state workers' compensation.

Item #15 - Indicate whether you have filed for an award under Section 5 of the Radiation Exposure Compensation Act. If you mark "yes," provide the claim number associated with that RECA claim.

Item #16 - Indicate whether you have filed for an award under Section 4 of the Radiation Exposure Compensation Act.

Privacy Act

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Energy Employees Occupational Illness Compensation Program Act (42 U.S.C. 7384 *et seq.*) (EEOICPA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has received will be used to determine eligibility for, and the amount of, benefits payable under EEOICPA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agencies or private entities that employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider other relevant matters. (4) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical rehabilitation, making evaluations for the Office of Workers' Compensation Programs and for other purposes related to the medical management of the claim. (5) Information may be given to Federal, state, and local agencies for law enforcement purposes, to obtain information relevant to a decision under the EEOICPA, to determine whether benefits are being paid properly, including whether prohibited payments have been made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the Debt Collection Act. (6) Disclosure of the claimant's social security number (SSN) or tax identification number (TIN) is mandatory. The SSN or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (7) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision.

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 17 minutes per response, including time for reviewing instructions, searching existing data sources, gathering the data needed, and completing and reviewing the collection of information. If you have any comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210. **Do not submit the completed claim form to this address.** Completed claims are to be submitted to the appropriate district office of the Office of Workers' Compensation Programs. Persons are not required to respond to the information collections on this form unless it displays a currently valid OMB number.