(INSERT LETTERHEAD)

Date

Employee:
File Number:

Name
Address
City, State ZIP

Dear Mr./Ms. (Last Name):

This letter is in regard to your claim for compensation under the Energy Employees Occupational Illness Compensation Program Act of 2000, as amended.

We have reviewed the claim and have determined that one of the following potentially radiogenic cancers has been diagnosed:

- Primary Trachea
- Bronchus
- Lung

The next step in the process of determining your eligibility for any benefits is calculating the probability of causation. This is essentially a finding whether the diagnosed cancer is reasonably related to exposure to radioactive materials while employed. The calculation of probability is based on many factors, such as the length of exposure and proximity to radiological sources, the type of safety protection worn, the type of cancer diagnosed, etc.

Another factor that must be included in the calculation for these particular cancers is the smoking history of the employee. In order to proceed with the calculation of probability for a claim involving primary trachea, bronchus, or lung cancer, we will need to know certain information about the employee’s smoking history immediately prior to the diagnosis of cancer. This smoking information will be used to calculate the probability of causation.

Attached to this letter is an enclosure that must be completed in order for the claim to proceed. Please fill out the enclosure fully and return it to the address that appears at the bottom. We ask that the enclosure be returned within thirty (30) days so as to avoid any delay in the claims adjudication process.

The attached enclosure must be completed and returned. Without the completed enclosure, we will be unable to calculate the probability of causation in your claim. Without this calculation, a determination concerning your entitlement to monetary benefits cannot be issued.

If you have any questions or concerns, please contact the District Office at (Insert Number) or FAX (Insert Number).

Sincerely,

Printed Name
Title

Enclosure: EN-8

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 the 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

We estimate that it will take an average of five (5) minutes to respond to this collection of information, which includes time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the U.S. Department of Labor, OWCP, Room S-3524, 200 Constitution Avenue, NW, Washington, DC 20210. DO NOT SEND THE COMPLETED FORM TO THIS ADDRESS. Persons are not required to respond to this collection of information unless it displays a currently valid OMB number.

Employee: (Insert) File Number: (Insert)

1. What is the best description for the employee named above?

☐ **Never Smoked**

☐ **Former Smoker** - The employee quit smoking more than five years before the date of cancer diagnosis

☐ **Current Smoker** – The employee smoked cigarettes at the time of the cancer diagnosis or quit smoking fewer than five years before the date of cancer diagnosis

2. If you selected Current Smoker, check the box that corresponds with the number of cigarettes smoked per day* at the time of the cancer diagnosis:

☐	Less than 10 per day
☐	10 - 19 per day
☐	20 - 39 per day
☐	40+ per day

* Generally 20 Cigarettes Per Pack

Any person who knowingly makes any false statement, concealment of fact, misrepresentation, or commits any other act of fraud to obtain compensation as provided under the 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.

I certify that the information provided is accurate and true.

Print Name: _____

Signature: _____

Date: _____

Return Form to: OFFICE OF WORKERS' COMPENSATION PROGRAMS
DIVISION OF ENERGY EMPLOYEES OCCUPATIONAL
ILLNESS COMPENSATION
(Address 1)
(Address 2)
(City, State ZIP)