File Number: «CaseNumber»
«FORM»-«CAT»-«SUBJ»

U.S. DEPARTMENT OF LABOR

«SenderAddress»
Phone: «SenderPhone»

February 6, 2021

Date of Injury: «DtInjury»
Employee: «ClaimantFullName»

«ToAddress»

Dear «Salutation»:

On behalf of the Office of Workers' Compensation Programs, please accept our condolences on the death of «ClaimantFullName». It appears that additional money was due at the time of the death.

Before we can determine the amount due or to whom it should be paid, all uncashed compensation checks must be returned to this office. Also, the enclosed questionnaire should be completed by the administrator of the estate, if one has been appointed. Otherwise, the next of kin should complete it. The completed form should be sent to this office with a copy of the death certificate.

Unnecessary delays may be avoided if the information requested is furnished promptly and all payments made after the date of death are returned. If you have any questions or require any assistance, please contact this office.

Sincerely,

«SignatureName»
«SignatureTitle»

Enclosure: Questionnaire

OMB Clearance #1215-0155 Exp. Date 05/31/07

«CCAddresses»

File Number: «CaseNumber»
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QUESTIONNAIRE FOR COMPENSATION DUE AT DEATH

1. Name of the Deceased:

2. Date of Death:

3. Give the following information about relatives of the deceased who may be entitled to share in distribution of the estate:

Name Birth Date Relationship Address, City, State, Zip Phone

___________________/ _______/ __________/ _______________________________

___________________/ _______/ __________/ _______________________________

___________________/ _______/ __________/ _______________________________

___________________/ _______/ __________/ _______________________________

4. If an administrator or executor has been appointed, give their name and address; attach a copy of the appointment document.

5. Did the deceased die intestate (that is, having made no will)?

6. Name, address and telephone number of person completing this form:

7. Relationship of person completing this form to deceased:

I hereby certify that each and every statement made above is true and complete to the best of my knowledge and belief. I understand that any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions be punished by a fine or imprisonment, or both.

Signed:________________________________ Date:_____________________

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NOTICE TO RECIPIENT

Public reporting burden for this collection of information is estimated to be average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W. Washington, D.C. 20210

Please note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.