

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»:

Compensation may continue to be paid on behalf of an unmarried child age 18 or older who is either a full-time student or incapable of self-support. We need additional information to determine whether «usr_CHILD_NAME» has continuing eligibility for compensation beyond the eighteenth birthday.

«usr_OPTIONAL_PARAGRAPHS_1»

The law prohibits the acceptance of compensation when a dependent is no longer entitled to it. If the dependent is «usr_OPTIONAL_PARAGRAPHS_NNL_2»

Any compensation payment you receive after such a change in status of the dependent must be returned to this office for cancellation. It will be replaced with a payment in the correct amount.

Sincerely,

«SignatureName»
«SignatureTitle»

Enclosures

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

«CCAddresses»

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NOTICE TO RECIPIENT

Public reporting burden for this collection of information is estimated to be average 30 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.

PART A- TO BE COMPLETED BY CLAIMANT

1. Name of dependent for whom you claim compensation: _____

2. Date of dependent's birth: _____

3. Dependent's Social Security Number: _____

4. Has the dependent completed four years of education beyond high school? _____

5. Has the dependent married? _____ If so, give the date of marriage. _____

6. Is the dependent now attending school on a full-time basis? _____
If so, on what date did attendance at this school begin? _____

7. Have you applied for educational benefits for this dependent from the Department of Veterans Affairs (VA)? _____
If so, have you received educational benefits from the VA? _____ Date benefits began: _____

I certify that the information given by me on this questionnaire is true, correct, and complete to the best of my knowledge. Any information left blank on this form has been done intentionally and indicates I had no information to provide for that question. I understand that any false statement, misrepresentation, or concealment of fact, in respect to this claim, may be grounds for forfeiture of compensation benefits and could subject me to civil liability or, if fraudulent, may result in criminal prosecution.

Signed _____ Date _____

Address _____

(Street)

(City)

(State)

(Zip)

PART B- TO BE COMPLETED BY SCHOOL OFFICIAL

Please refer to the accompanying Part A.

1. Is «usr_CHILD_NAME» currently enrolled in your institution fulltime?
2. Name and address of educational institution:

3. What are the beginning and ending dates of the present school year?
4. When should this student expect to complete the present course of study?
5. Is your school an accredited or licensed institution?

I have reviewed Part A and I certify that the information given by me on this questionnaire is true, correct, and complete to the best of my knowledge.

Signed _____

Title _____

Date _____

Return Parts A and B together to the following address:

U.S. Department of Labor
DFEC Central Mailroom
P.O. Box 8300
London, KY 40742-8300