Claim for Additional Wage-Loss and/or Impairment 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 No. 1215-0197 Expiration Date: 08/31/2007

Employee's Information (print clearly)

1. Name (Last, First, Middle Initial)	**2. Social Security Number**
3. Address (Street, Apt. #, P.O. Box)	**4. Telephone Number(s)** a. Home: ( ) -
(City, State, ZIP Code)	b. Other: ( ) -

Compensation is Claimed for: (Check one or both boxes and provide the requested information)

☐ **Wage Loss** - Claims for additional wage loss may only be submitted if at least one year has elapsed since you were awarded compensation for wage loss, and can only be claimed in calendar year increments. Multiple years can be claimed as long as it has been one (1) year since the previous award for wage loss. However, this claim form may not be used to claim for prior years of wage loss that have already been rejected.

Indicate the calendar year(s) wage loss was sustained and provide the gross earnings for each year claimed. DO NOT list any years in which OWCP either paid or denied compensation for wage loss.

1.	Calendar Year of Wage Loss:		Total Gross Earnings:	**$**
2.	Calendar Year of Wage Loss:		Total Gross Earnings:	**$**
3.	Calendar Year of Wage Loss:		Total Gross Earnings:	**$**
4.	Calendar Year of Wage Loss:		Total Gross Earnings:	**$**
5.	Calendar Year of Wage Loss:		Total Gross Earnings:	**$**

☐ **Increased Impairment Rating** - Claims for an increased permanent impairment rating may only be submitted if at least two (2) years has elapsed since you were last awarded impairment benefits.

Provide the increase in impairment since the last award of impairment benefits.

Increase in Impairment **%**

Declaration of the Person Completing this Form

Any person who knowingly makes any false statement, misrepresentation, concealment of fact of 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. In addition, a felony conviction will result in termination of all current and future EEOICP benefits. I affirm that the information provided on this form is accurate and true.

Resource Center Date Stamp

_____ (Signature)

_____ (Date)

Instructions for Completing Form EE-10

This form is used by employees to claim additional wage loss and/or impairment rating for a claim filed under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). The employee must claim for an additional year(s) of wage loss, for increased impairment rating, or both. Both claims must be supported by sufficient evidence to establish that the claimant is entitled to the benefits claimed.

Wage Loss - Claims for additional wage loss may only be submitted by employees and only if at least one year has elapsed since any previous awarded compensation for wage loss, and can only be claimed in calendar year increments. Multiple years can be claimed as long as it has been one (1) year since the previous award for wage loss. However, this claim form may not be used to claim for prior years of wage loss that have already been rejected. Any claim for wage loss must be supported by sufficient factual and medical evidence of another calendar year of compensable wage loss.

- **Calendar Year of Wage Loss**: A calendar year is defined as the twelve-month period from January through December. Do not list days or months; just the calendar year(s).

- **Total Gross Earnings**: Show the total wages earned, before any payroll deductions, during the claimed calendar year.

Increased Impairment Rating - Claims for an increased permanent impairment rating may only be submitted by employees and only if at least two (2) years has elapsed since the last awarded impairment benefits. Any claim for increased impairment rating must be supported by medical evidence of an increased minimum impairment rating due to a covered illness or illnesses. The employee must provide the percentage increase in impairment since the last award of impairment benefits, and supporting medical documentation.

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 five (5) 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.

Form EE-10
April 2005