Date Telephone number

File Number:
Claimant:
Accepted Condition(s):

JOHN Q. CLAIMANT
1111 MAIN STREET
OAK RIDGE, TN 44444

Dear Mr. Claimant:

The information requested in the attached enclosure is required in connection with your claim for benefits under the Energy Employees Occupational Illness Compensation Program Act of 2000 (EEOICPA), 42 U.S.C. § 7384 *et seq*. This information will be used to ensure that we have current contact information for you, and to verify that you are eligible to continue receiving medical or other benefits for your accepted conditions as shown above. The form also provides you with an opportunity to provide us with any concerns regarding your current medical treatment for your accepted conditions, and in some cases, to initiate review of potential additional impairment or wage-loss benefits.

Please completely answer all questions and return the enclosure within 30 days of the date of this letter. Pub. L. 100-503 provides that the statements on the enclosure and other information in your claim file may be verified through computer matches. OWCP may also request that you submit additional factual evidence to support your statements, if needed.

READ ALL INSTRUCTIONS CAREFULLY BEFORE FILLING OUT THE ENCLOSURE. YOU MUST ANSWER ALL OF THE QUESTIONS. IF THE QUESTION DOES NOT APPLY TO YOUR CLAIM, STATE “NOT APPLICABLE (N/A)” OR “NONE.”

If you need more space to fully answer any of the questions, use another sheet of paper with your name and claim number at the top. Sign and date each extra sheet.

Expiration Date: February 2007

When you have completed the enclosure, **sign it and return it to the address shown at the top of this letter**. Your signature certifies that you have supplied all information requested by the enclosure. If you have any questions about completing the enclosure, call me at (111) 222-3333 or write to me at the above address.

Sincerely,

****

CLAIMS EXAMINER

Enclosure: EN-12

NOTICE TO RECIPIENT

Public reporting burden for this collection of information is estimated to average 20 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 the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, OWCP, Room S3524, 200 Constitution Avenue, NW, Washington, DC 20210. DO NOT SEND THE COMPLETED FORM TO THIS ADDRESS. Persons are not required to complete this form unless it displays a currently valid OMB number.

File Number: Claimant:

SECTION A – CURRENT CONTACT INFORMATION

If you have moved or have a different mailing address from the one shown at the top of the first page of the accompanying letter, provide the current information in the space provided below. (Do not complete if the information is correct). Also, please provide a current telephone number.

Name:_____
Address:_____
City and State:_____
Zip Code:_____
Telephone Number:_____

SECTION B – CURRENT MEDICAL CONDITION

Do you have any concerns regarding treatment for your accepted medical conditions as shown on the letter that accompanied this form? Yes or No: _____

If yes, please describe your concerns:
_____
_____
_____
_____

Do you wish to claim additional compensation for impairment due to your accepted condition? Yes or No: _____

Do you wish to claim additional compensation for wage-loss? (Wage-loss benefits are payable only if the wages were lost prior to your regular Social Security retirement age.) Yes or No: _____

Would you like for your claims examiner to contact you by telephone regarding your concerns? Yes or No: _____

File Number: Claimant:

SECTION C – STATE WORKERS' COMPENSATION

1. Have you filed for and/or received any state workers' compensation for your accepted condition(s) since you were awarded EEOICPA benefits? Yes or No: _____

2. If you answered "Yes," please tell us the following information:

Date of filing:_____
State in which you filed:_____
Name of employer, insurer or state that paid:_____
Amount of monetary benefits received: $_____
Type of benefits (disability, impairment, etc.):_____

List the same information for any other state workers' compensation received after being awarded EEOICPA benefits on an extra sheet.

SECTION D – TORT AWARDS OR SETTLEMENTS

1. Since you were awarded EEOICPA benefits, have you received any settlement or award from a claim or tort suit (other than a claim for workers' compensation) against a third party in connection with an exposure to a toxic substance for which you received EEOICPA benefits? Yes or No: _____

2. If you answered "Yes," please tell us the following information:

Date of award or settlement:_____
Party or parties involved:_____
Type of suit or settlement:_____
Amount of award or settlement: $_____

List any other tort awards or settlements below or on an extra sheet.

SECTION E – CERTIFICATION

I know that anyone who fraudulently conceals or fails to report information that would have an effect on benefits, or who makes a false statement or misrepresentation of a material fact in claiming a payment or benefit under the Energy Employees Occupational Illness Compensation Program Act may be subject to criminal prosecution, from which a fine and/or imprisonment may result.

I understand that I must immediately report to OWCP any state workers' compensation benefits or tort awards/settlements I receive.

I certify that all the statements made in response to questions on this enclosure are true, complete and correct to the best of my knowledge and belief. I have placed "Not Applicable (N/A)" or "None" next to those questions that do not apply to me or my claim.

_____ _____

Signature Date