

Date

Telephone number

STATE WORKERS' COMPENSATION AGENCY
STREET ADDRESS
CITY, STATE ZIP CODE

The information requested in the attachments is required in connection with claims for benefits under the Energy Employees Occupational Illness Compensation Program Act of 2000 (EEOICPA), 42 U.S.C. § 7384 *et seq.* Section § 7385s-11 of the EEOICPA provides for coordination of benefits with respect to state workers' compensation as follows:

(a) IN GENERAL.—An individual who has been awarded compensation under this part, and who has also received benefits from a State workers' compensation system by reason of the same covered illness, shall receive compensation specified in this part reduced by the amount of any workers' compensation benefits, other than medical benefits and benefits for vocational rehabilitation, that the individual has received under the State workers' compensation system by reason of the covered illness, after deducting the reasonable costs, as determined by the Secretary, of obtaining those benefits under the State workers' compensation system.

* * *

(c) INFORMATION.—Notwithstanding any other provision of law, each State workers' compensation authority shall, upon request of the Secretary, provide to the Secretary on a quarterly basis information concerning workers' compensation benefits received by any covered DOE contractor employee entitled to compensation or benefits under this part, which shall include the name, Social Security number, and nature and amount of workers' compensation benefits for each such employee for which the request was made.

The first attached list contains the names of employees who worked at facilities in your state on whose behalf a claim under

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Part E of EEOICPA has been accepted during the last year. The second list contains the names of employees for whom we have made a previous inquiry. For each employee, we have listed the name(s) of the claimant(s), whether the claimant is the employee or a survivor, the Social Security Number of the employee, the accepted medical condition, and the date eligibility began. For each entry on the first list, please indicate whether or not a state workers' compensation claim has been filed on behalf of that same worker, the name(s) of the claimant, and whether the claim has been accepted, and if accepted, the accepted medical condition, the effective date of the award, and the amount of the award. For each entry on the second list, please indicate whether there has been any change since the last time information was provided.

If you have questions about this request, please contact XXXXXXXX XXXXXXXX at (111) 222-3333.

Thank you for your assistance.

Sincerely,

Peter M. Turcic
Director, Division of Energy Employees Occupational Illness
Compensation

Enclosure: EN-13

NOTICE TO RECIPIENT

Public reporting burden for this collection of information is estimated to average 16 hours 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.

Employee Name	Claimant Name	E or S	Employee SSN	Accepted Condition	Effective Date
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