Certification of Funeral Expenses

Print Reset

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs

The information provided on this form will be used to determine the amount of funeral expenses that are payable. Completion of the form is required to obtain payment for services performed (20 CFR § 702.121.) Persons are not required to respond to this collection of information unless it contains a currently valid OMB control number.

OMB No. 1215-0027
Expires: 04-30-2008

For Office Use

1. OWCP No.
2. Carrier's No.

3. Name of deceased

First Name | M.I. | Last Name

4. Funeral Director (Name, address, ZIP code)

name:
line 1: city: country:
line 2: state: zip:

5. **Services Performed**
(itemize below and enter costs)

Comments

(If additional space is required continue on reverse)

Total Bill	
Amount Paid	
Amount Due	

6. I was informed that the above bill would be paid by

Enter name, address, and relationship to deceased.

name: relationship:
line 1: city:
line 2: state: zip: ctry:

7. This amount, $_____, of the bill was paid by

Enter name, address, and relationship to deceased.

name: relationship:
line 1: city:
line 2: state: zip: ctry:

Certification

I certify that this concern performed the above services and that no further part of this bill has been paid.

It is therefore requested that payment, in accordance with the Longshore and Harbor Workers' Compensation Act or its extensions, be paid for the services indicated above.

8. Signature and title (Type and sign)

name:
title:

9. Date signed

Public Burden Statement

We estimate that it will take an average of 15 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Division of Longshore and Harbor Workers' Compensation, Room C4315, 200 Constitution Avenue, N.W., Washington, D.C. 20210. DO NOT SEND COMPLETED FORMS TO THIS OFFICE.