OMB Number: 1215-XXXX
Expiration Date: Month XX, XXXX

Official Notice of Employees' Death for Purposes of FECA Section 8102a Death Gratuity (CA-42)

Instructions on Completing Form CA-42. Complete each item as completely as possible and include a copy of the death certificate and a copy of the most recent CA-40 beneficiary designation. Please sign and date the form noted on page 4 and forward it to Office of Workers' Compensation Programs' Division of Federal Employees' Compensation.

Deceased Employee Information

1. Name (Last, First, Middle) 2. Sex ☐ Male ☐ Female 3. Social Security Number

4. DOB 5. DOD 6. Employing Agency

7. Employee's position with the agency

Circumstances of the employees' injury/death

8. Date and hour of injury 9. Location where the injury occurred

10. Date that the employee's immediate supervisor first had knowledge of the injury

11. Describe how the injury occurred

12. Was the employee in the performance of duty when the injury occurred.
☐ Yes ☐ No

13. What were the employee's assigned duties at the time of death?

14. Were the employee's duties being performed in connection with an Armed Force contingency operation? ☐ Yes ☐ No
If yes, please indicate which Armed Force and what operation

Include a copy of the employee's death certificate with this form.

Survivor Information

15. Did the employee complete a Designation of a Recipient of the Death Gratuity Payment (CA-40) or otherwise indicate, in writing, a designation? ☐ Yes ☐ No

If yes, provide a copy of the form CA-40 or other pertinent written documentation.

Include any completed CA-41 forms the employee's agency received from survivors or alternate beneficiaries.

16. Did the employee have any living survivors or alternate beneficiaries? ☐ Yes ☐ No

Please list all potential beneficiaries.

Name	Relationship to decedent	Address	Phone Number(s)

Other Death Gratuity Benefits Paid

17. Were any death gratuity benefits paid under any other law of the United States for this death? ☐ Yes ☐ No

If yes, please provide the following information:

a. Administering agency name, contact and address: Claim #: Amount paid:

b. Administering agency name, contact and address: Claim #: Amount paid:

c. Administering agency name, contact and address: Claim #: Amount paid:

Employing Agency Certification

As a representative of the employing agency, I hereby certify that the information provided above concerning coverage of the employee under section 8102a of the Federal Employees' Compensation Act is true and accurate to the best of my knowledge and belief.

Signature of Agency Official_____ Date_____

Official Name:_____

Official Title: _____

Address: _____

Phone: _____

Privacy Act Statement

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act (FECA), as amended and extended (5 U.S.C. 8101, et seq.) including the Death Gratuity in section 1105 of Public Law 110-181 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 will be used to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency which 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 issues relating to entitlement to benefits or other relevant matters. (4) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection Act. (5) Disclosure of the claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory (Executive Order 9397, dated November 22, 1943). The SSN (and/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. (6) 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 or reduced level of benefits.

Public Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB number. 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 the data needed, and completing and reviewing the collection of information. The obligation to respond to this collection is required to obtain or retain benefit (5. U.S.C. 8102a). Send comments regarding the 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 S3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210, and reference the OMB Control Number 1215-XXXX. Note: **Do not submit the completed claim form to this address.** Completed notices are to be submitted to the appropriate district office of the Office of Workers' Compensation Programs.