Claim for Survivor Benefits 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.

Submit | Reset | Print

OMB Number: 1215-0197
Expiration Date: 08/31/2007

Deceased Employee Information (Please Print Clearly)

1. Name (Last, First, Middle Initial)

2. Sex ☐ Male ☐ Female

3. Social Security Number

4. Date of Birth Month / Day / Year

5. Date of Death Month / Day / Year

6. Was an autopsy performed on the employee?
☐ YES - List Medical Facility:
☐ NO ☐ DON'T KNOW

Survivor Information (Please Print Clearly)

7. Name (Last, First, Middle Initial)

8. Sex ☐ Male ☐ Female

9. Social Security Number

10. Date of Birth Month / Day / Year

11. Your relationship to the deceased employee
☐ spouse ☐ child ☐ step-child ☐ parent
☐ grandparent ☐ grandchild ☐ Other:

12. Address (Street, Apt. #, P.O. Box)

(City, State, ZIP Code)

13. Telephone Numbers
a. Home: ( ) -
b. Other: ( ) -

14. Identify the Diagnosed Condition(s) Being Claimed as Work-Related (check box and list specific diagnosis)

	15. Date of Diagnosis Month	Day	Year
☐ **Cancer** (List Specific Diagnosis Below)			
a.			
b.			
c.			
☐ **Beryllium Sensitivity**			
☐ **Chronic Beryllium Disease** (CBD)			
☐ **Chronic Silicosis**			
☐ **Other Work-Related Condition(s) due to exposure to toxic substances or radiation** (List Specific Diagnosis Below)			
a.			
b.			
c.			

Awards and Other Information

16. Did the employee work at a location designated as a Special Exposure Cohort (SEC)?	☐ YES ☐ NO
17. Have you or the deceased employee filed a lawsuit seeking either money or medical coverage for the claimed condition(s)?	☐ YES ☐ NO
18. Have you or the deceased employee filed any workers' compensation claims in connection with the claimed condition(s)?	☐ YES ☐ NO
19. Have you, the deceased employee, or another person received a settlement or other award in connection with the above claimed condition(s)?	☐ YES ☐ NO
20. Have you either pled guilty or been convicted of any charges connected with an application for or receipt of federal or state workers' compensation?	☐ YES ☐ NO
21. Have you or the employee applied for an award under Section 5 of the Radiation Exposure Compensation Act (RECA)? **If yes, provide RECA Claim #:**	☐ YES ☐ NO
22. Have you or the employee applied for an award under Section 4 of the Radiation Exposure Compensation Act?	☐ YES ☐ NO

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Other Potential Survivors

23. Are you aware of any person(s) who may also qualify as a survivor of the deceased employee? ☐ YES ☐ NO

If YES, please provide the following:

	Name	Relationship to the deceased employee	Address	Phone Number(s)
a.				Home: Other:
b.				Home: Other:
c.				Home: Other:
d.				Home: Other:
e.				Home: Other:
f.				Home: Other:
g.				Home: Other:
h.				Home: Other:
i.				Home: Other:
j.				Home: Other:

Survivor Declaration

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or 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. Any change to the information provided on this form once it is submitted must be reported immediately to the District Office responsible for the administration of the claim. I hereby make a claim for benefits under EEOICPA and affirm that the information I have provided on this form is true. If applicable, I authorize the Department of Justice to release any requested information, including information related to my RECA claim, to the U.S. Department of Labor, Office of Workers' Compensation Programs (OWCP). Furthermore, I authorize any physician or hospital (or any other person, institution, corporation, or government agency, including the Social Security Administration) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs.

Claimant Signature

Date

Resource Center Date Stamp

Form EE-2
April 2005

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Instructions for Completing Form EE-2

Complete all items on the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. If the requested information is not submitted, the responsible party should explain the reason(s) for the delay and indicate when the information will be forthcoming. Submit the completed claim form and all other pertinent documentation to the appropriate district office administering the EEOICPA in the region where the employee's most recent Energy employer is/was located.

Deceased Employee Information

Item #14 - Identify the employee's physician-diagnosed condition(s) that you claim are work related. Do not list the symptoms (e.g. aches, pains, cough, wheezing, breathing problems, etc.) associated with the diagnosed condition(s). Attach to the claim form any pertinent medical documentation and copy of the employee's death certificate. If you require additional space, attach a signed supplemental statement to this form.

Item #15 - List the date a qualified physician first diagnosed the claimed condition(s).

Awards and Other Information

Item #16 - The EEOICPA allows for employees who have met particular criteria and have been employed at certain facilities to be designated as members of the Special Exposure Cohort (SEC). Indicate whether or not the deceased employee worked at a location designated as an SEC.

Item #17 - Indicate whether you or the deceased employee have filed a civil lawsuit in regard to the claimed condition(s). If you mark YES, provide copies of all court documentation.

Item #18 - Indicate whether you or the deceased employee have filed any workers' compensation claims in connection with the claimed condition(s). If you mark YES, provide copies of all workers' compensation documentation.

Item #19 - Indicate whether you, the deceased employee or another person received a settlement or other type of award for a lawsuit or a workers' compensation claim in connection with the claimed condition(s)? If YES, provide copies of all pertinent documentation.

Item #20 - Mark the appropriate box indicating whether or not you have ever pled guilty or been convicted of any charges connected to an application for or receipt of federal or state workers' compensation.

Item #21 - Indicate whether you or the deceased employee filed for an award under Section 5 of the Radiation Exposure Compensation Act. If you mark "yes," provide the claim number associated with that RECA claim.

Item #22 - Indicate whether you or the deceased employee filed for an award under Section 4 of the Radiation Exposure Compensation Act.

Other Potential Survivors

Item #23 - Every eligible survivor of a covered employee must be identified prior to the payment of any compensation. If you are aware of any individual who may also qualify as a survivor of the deceased employee, provide his/her name and any additional information requested in this item. Under the EEOICPA, certain limitations apply to the definition of persons who may qualify as an eligible survivor. Eligible survivors of a deceased employee may include: surviving spouse, child (natural, step, or adopted), parent, grandchild, or grandparent. Any claim for survivor benefits must be accompanied by proof of relationship to the deceased employee. This includes, but may not be limited to, a copy of a marriage certificate, birth certificate, or adoption papers.

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 employee at the time of injury 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 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 21 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.