File Number: «CaseNumber»
CA-1032-FO-CA1032

U.S. DEPARTMENT OF LABOR

«SenderAddress»
Phone: «SenderPhone»

February 2, 2021

Date of Injury: «DtInjury»
Employee: «ClaimantFullName»

«ToAddress»

Dear Sir/Madam:

The information requested in this letter is required in connection with your benefits under the Federal Employees' Compensation Act (FECA), 5 U.S.C. 8101 et seq. This information will be used to decide whether you are entitled to continue receiving these benefits, or whether your benefits should be adjusted.

You must completely answer all questions and return this statement with in 30 days of the date of this letter. Otherwise, your benefits will be suspended in accordance with 20 CFR 10.528. Public Law 100-503 provides that the statements on this form and other information in your claim file may be verified through computer matches.

READ ALL INSTRUCTIONS CAREFULLY BEFORE FILLING OUT YOUR STATEMENT. 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.

WARNING

A FALSE OR EVASIVE ANSER TO ANY QUESTION, OR THE OMISSION OF AN ANSWER, MAY BE GROUNDS FOR FORFEITING YOUR COMPENSATION BENEFITS AND SUBJECT YOU TO CIVIL LIABILITY. A FRAUDULENT ANSWER MAY RESULT IN CRIMINAL PROSECUTION. ALL STATEMENTS ARE SUBJECT TO INVESTIGATION FOR VERIFICATION.

This statement covers the 15 months prior to the date you complete and sign the form. Your signature at the end of the statement certifies that you have supplied all information requested for that period of time.

When you have completed the form, return it to the address shown at the top of this letter. If you have any questions about the completion of this form, call your district office.

File Number: «CaseNumber»
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Sincerely,

«SignatureName»
«SignatureTitle»

Enclosure(s): EN1032 (5 pages)

OMB No. 1215-0151 Expires: 02-29-2008

«CCAddresses»

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 US Department of Labor, OWCP, Room S3229, 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 control number.

PRIVACY ACT

"NOTE: The following statement is made in accordance with the Privacy Act of 1974 (5 USC 552a) and the Paperwork Reduction Act of 1995, as amended. The authority for requesting the following information is Section 8101, et seq., Title 5 of the U.S. Code authorizes collection of this information. **Completion of this form is required in connection with your benefits under the FEDERAL EMPLOYEES' COMPENSATION ACT(FECA). The information will be used to decide whether you are entitled to continue receiving these benefits or whether your benefits should be adjusted.** Additional disclosures of this information may be to: third parties in litigation; employing agencies, various individuals and organizations providing related medical rehabilitation and other services; insurance plans which may have paid related bills; labor unions; various law enforcement officials; other federal, state and local agencies (including the GAO and IRS) as appropriate; data processing contractors to the Department of Labor; debt collection agencies and credit bureaus."

File Number: «CaseNumber»
Employee: «ClaimantFullName»
February 2, 2021

PART A--EMPLOYMENT

Read this section completely before answering the questions below and on the next page.

Report ALL employment for which you received a salary, wages, income, sales commissions, piecework, or payment of any kind. Such employment includes service with the military forces of the United States, including the National Guard, Reserve component, or other affiliates.

Report ALL self-employment or involvement in business enterprises. These include but are not limited to: farming; sales work; operating a business, including a store or a restaurant; and providing services in exchange for money, goods, or other services. The kinds of services which you must report include such activities as carpentry, mechanical work, painting, contracting, child care, odd jobs, etc. Report activities such as keeping books and records, or managing and/or overseeing a business of any kind, including a family business. Even if your activities were part-time or intermittent, you must report them.

Report as your "rate of pay" what you were paid. Include the value of such things as housing, meals, clothing, and reimbursed expenses, if they were received as part of your employment.

Report ANY work or ownership interest in any business enterprise, even if the business lost money or if profits or income were reinvested or paid to others. If you performed any duties in any business enterprise for which you were not paid, you must show as rate of pay what it would have cost the employer or organization to hire someone to perform the work or duties you did, even if your work was for yourself or a family member or relative. You need not list ownership in any publicly traded businesses.

SEVERE PENALTIES MAY BE APPLIED FOR FAILURE TO REPORT ALL WORK ACTIVITIES THOROUGHLY AND COMPLETELY.

1. **Did you work for any employer during the past 15 months?**

   a. Yes or No: _____
   b. If yes, state for each employer:
   Dates of employment: _____
   Description of work done: _____
   Rate of pay: $_____/hr/wk/mo Actual earnings: $_____
   Name/address of employer: _____
   _____

2. **Were you self-employed or involved in any business enterprise in the past 15 months?**

   a. Yes or No: _____
   b. If yes, state:
   Dates of self-employment or involvement in business enterprise: _____
   _____
   Description of work or business involvement: _____
   _____

PART A--EMPLOYMENT (Continued)

Rate of pay: $_____/hr/wk/mo Actual earnings: $_____
Name/Address of place of employment or business:
_____
_____

3. **If you answered "No" to both questions 1 and 2**, state whether you were unemployed for all periods during the past 15 months: Yes or No: _____
If no, show dates of employment: _____

PART B--VOLUNTEER WORK

During the past 15 months, did you perform any volunteer work for which ANY FORM of monetary or in-kind compensation was received? Yes or No: _____ If yes, state the kind of work you did:
_____
What were the beginning and ending dates of the volunteer work?
_____
How often did you perform this work (hours per week, weeks per month, etc.)?:
_____

PART C--DEPENDENTS

A claimant who has no eligible dependents is paid compensation at 66 2/3 % of the applicable pay rate. A claimant who has one or more eligible dependents is paid compensation at 75% of the applicable pay rate. You must answer the questions below to ensure your compensation is paid at the correct rate.

You may claim compensation for a dependent if you have one or more of the following: (a) a husband or wife who lives with you; (b) an unmarried child, including an adopted child or stepchild, who lives with you and is under 18 years of age; (c) an unmarried child who is 18 or over, but who cannot support himself or herself because of mental or physical disability; (d) an unmarried child under 23 years of age who is a full-time student and has not completed four years of school beyond the high school level; (e) a parent who totally depends upon you for support.

You may also claim compensation for a husband, wife or dependent who does not live with you if a Court has ordered you to pay support to that person. Finally, you may claim compensation for (a) a husband or wife, (b) an unmarried child under 18, or (c) an unmarried child between 18 and 23 who is a full-time student even if that person does not live with you, as long as you make regular direct payments for his or her upport.

1. Are you married? Yes or No: _____ If yes, does your husband or wife live with you? Yes or No: _____ If no, do you make regular direct payments for his or her support? Yes or No: _____

PART C--DEPENDENTS Continued)

2. Do you claim compensation on account of other dependents, such as children? Yes or No: _____

   If yes, complete the following for each dependent:

   Full Name: _____
   Date of Birth: _____
   Relationship to You: _____

   List any other dependents on an extra sheet.

3. If you are receiving compensation for a dependent and are no longer entitled to receive that compensation, state:

   Date the person stopped being a dependent _____
   Reason the person stopped being a dependent _____
   _____

PART D--OTHER FEDERAL BENEFITS OR PAYMENTS

1. **OPM Benefits.** Report any retirement benefits (either disability or regular) you receive from the Office of Personnel Management (OPM), the Foreign Service, or any other Federal disability or retirement system except for benefits under the FECA.

   a. Have you been assigned a CSA number? Yes or No: _____
   If yes, write it here: _____

   b. During the past 15 months, have you received a:
   Regular retirement check? Yes or No: _____
   Disability retirement check? Yes or No: _____

2. **SSA Benefits.** Report any benefits received from the Social Security Administration (SSA) which you receive as part of an annuity under the Federal Employees' Retirement System (FERS). DO NOT report any benefits received from the SSA on account of employment in the private sector.

   a. Do you receive benefits from the SSA as part of an annuity for Federal service? Yes or No: _____

3. **VA Benefits.** Report any increase in a Veterans Administration (VA) disability award resulting from the injury for which you receive benefits under the FECA.

   a. Do you receive benefits from the VA on account of service in the Armed Forces of the United States? Yes or No: _____

   b. If yes, state your file number: _____
   Also state the kind of disability for which the award was made: _____
   _____

PART D--OTHER FEDERAL BENEFITS OR PAYMENTS (Continued)

c. Has the percentage of your VA award increased since the injury for which you are receiving benefits under the FECA?

Yes or No: _____ If yes, give date of increase: _____

4. **Other Benefits.** Report any Federal Black Lung benefits or any other benefits paid by the Federal government, not including benefits under the FECA.

a. Have you received any other Federally funded or assisted benefits, such as described above? Yes or No: _____

b. If yes, provide the following information for each such benefit or payment:

Type of Claim/Award/Benefit: _____
Agency and Address: _____
_____
Claim or File No.: _____
Amount/Value Received _____ Weekly or Monthly? _____
Dates for which benefits received: _____
Do you still receive these benefits regularly? Yes or No: _____

PART E--THIRD PARTY SETTLEMENT

1. In the past 15 months, did you receive any settlement or award from a claim or suit against a third party in connection with an injury or illness for which you receive compensation? Yes or No: _____

2. If yes, state:

Date of judgment or settlement: _____
Party or parties involved: _____
Type of suit or settlement: _____
Amount of judgment or settlement: _____
Legal fees and Court costs: _____

PART F—FRAUD/FELONY OFFENSES

1. Have you been convicted of any fraud – related offense in connection with the application for or receipt of workers' compensation benefits? Yes or No:_____
If yes, state date of conviction. _____

2. Have you been incarcerated for any period during the past 15 months for any felony offense?
Yes or No:_____

PART G--CORRECTIONS

If the name, address, file number, date of injury, or Social Security number (SSN) shown at the top of the first page of this letter is incorrect, provide the correct information in the space provided below. (Do not complete if the information is correct).

Name: _____ File Number: _____
Address: _____ Date of Injury: _____
_____ SSN: _____

PART H--CERTIFICATION

I know that anyone who fraudulently conceals or fails to report income or other information which 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 Federal Employees' Compensation Act may be subject to criminal prosecution, from which a fine or imprisonment, or both, may result.

I understand that I must immediately report to OWCP any improvement in my medical condition, any employment, any change in the status of claimed dependents, any third part settlement, and any change in income from Federally assisted disability or benefit programs.

I certify that all the statements made in response to questions on this form 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

_____ _____
Street Address Telephone

_____
City, State and Zip