Notice of Law Enforcement Officer's Death

Print Reset

U.S. Department of Labor
Office of Workers' Compensation Programs

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No. 1240-0022
Expires: XX-XX-XXXX

EMPLOYING ORGANIZATION'S REPORT

1. Name and Mailing Address Including ZIP Code of Employing Organization

2. Name of Deceased Officer's Immediate Superior

3. Name and Telephone Number of Person to Contact

4. Last, First, Middle Name of Deceased Officer

5. Officer's Birth Date (month, day, year)

6. Social Security Number

7. Officer's Last Mailing Address Including ZIP Code

8. Date and Hour of Injury AM ☐ PM ☐

9. Date of Death

10. Date and Hour Pay Stopped AM ☐ PM ☐

11. Rate of Pay on Date of Injury

Base	$	Per
Subsistence, If Extra	$	Per
Quarters, If Extra	$	Per

12. List and Show Value of Other Pay Increments on Date of injury

	$	Per
	$	Per

13. On Day of Injury Officer's Shift → a. Began AM ☐ PM ☐ b. Ended AM ☐ PM ☐

14. Number of Hours Worked Per Day (exclusive of overtime)

15. Circle Days Normally Worked Per Week (exclusive of overtime) SU MO TU WE TH FR SA

16. Did Officer Work for the Organization a Full 11 Months Immediately Prior to Injury? Yes ☐ No ☐

17. If No, Would His Job Have Afforded Employment For 11 Months Except For the Injury? Yes ☐ No ☐

18. Describe Nature of Injury Which Caused Death

19. Describe Fully How the Officer's Death Occurred While Enforcing the Laws of the United States. If possible, give the U.S. Code Citation.

20. Was Officer Performing Regular Duties When Injured? If No, Give Full Explanation

21. Was the Injury Caused By:

a. Officer's Willful Misconduct? Yes ☐ No ☐

b. Officer's intoxication? Yes ☐ No ☐

c. Officer's Intent to Bring About Injury to Self or Another (other than normally required in performance of duty)? Yes ☐ No ☐

Attach Detailed Explanation for Any "Yes" Answers

22. If Known, Give Name and Address of Suspect(s) or Witness(es) With Whom Officer Was Involved When Injured

23. Has Application Been Made for Compensation, Annuity, or Other Benefits as a Result of This Death Under Any Compensation Law, Police Death or Survivor's Benefit Fund, or Other Such Fund? Yes ☐ No ☐

If Yes, Give Name and Address of Organization With Which Application Was Filed.

24. Define, Explain, or Identify the Circumstances of This Injury Resulting in Death Which Involves the United States (see the first paragraph of the instruction sheet attached to this form).

We hereby certify that the officer, whose death is reported above, was injured while in performance of duty under 5 U.S.C. 8101 et seq., as extended by 5 U.S.C. 8191. All statements made in this report are true to the best of our knowledge and belief.	25. Signature	26. Date Signed
	27. Title	

IMPORTANT: Please attach a copy of any investigation report of this injury and death. If no report was made, a statement from each witness should be attached reporting what he saw, heard, or knows about the incident leading to injury and death.

ATTENDING PHYSICIAN'S MEDICAL REPORT

1. Last, First, Middle Name of Deceased Officer	2. Date of Death (month, day, year)

3. History of Injury

4. If Death Was Not Instantaneous, Describe Treatment Provided	5. Inclusive Dates on Which Treatment Was Given

6. Direct Cause of Death

7. Contributory Cause of Death

8. In Your Opinion, Was Death of the Officer Due to the Injury as Reported in Item 3? ☐ Yes ☐ No If No, State Your Reasons For Believing Death Resulted From Other Causes.

9. Was a Biopsy or Autopsy Performed? ☐ Yes ☐ No If So, By Whom?

10. I certify that the answers to the above questions are true to the best of my knowledge and belief. I am licensed to practice medicine and surgery in the state of	11. Signature	12. Date Signed
	13. Mailing Address Including ZIP Code	

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 control number. Public reporting burden for this collection of this information is estimated to average 60 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the date needed, and completing and reviewing the collection of information. The authority for requesting this information is 5 U.S.C. 8101 et seq. The information will be used to determine entitlement to benefits. Furnishing the requested information is required for the claimant to obtain or retain a benefit. 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 S3229, 200 Constitution Avenue, NW, Washington, DC 20210, and reference OMB Control Number 1240-0022. DO NOT SEND THE COMPLETED FORM TO THIS ADDRESS.

Claim on Behalf of Widow, Widower, or Children

1. Last, First, Middle Name of Deceased Officer	2. Date of Death (month, day, year)
3. Mailing Address Including ZIP Code of Surviving Spouse or Guardian	4. Nature of Injury Which Caused Death
5. Name of Officer's Former Employing Organization	

CLAIM OF SURVIVING SPOUSE	6. Date of Marriage to Officer	7. Was Spouse Living With Officer at Time of Death? ☐ Yes ☐ No	8. Number of Children Now Living Who Are the Issue of This Marriage
	9. Was Spouse Married at Any Time to Anyone Other Than Officer? ☐ Yes ☐ No	10. Was the Officer Married at Any Time to Anyone Else? ☐ Yes ☐ No	11. Date of Birth of Surviving Spouse

If answer to either items 9 or 10 is yes, submit documents to show dissolution of prior marriages, such as death certificates, divorce decrees.

12. List all Children of the Officer for Whom Claim is Being Made (those living at the time of his death and who were under 18, or who were over 18 and a student or incapable of self-support)

Name	Date of Birth	Living at Address Shown in Item 3?	If Not, Show Mailing Address
		☐ ☐	
		☐ ☐	
		☐ ☐	
		☐ ☐	

13. Has a Legal Guardian Been Appointed for Any of the Above-Named Children? ☐ Yes ☐ No If Yes, Give Name and Mailing Address of Guardian of Each Child and Attach a Certified Copy of Appointment Documents

14. List Any Other Relatives Who May be Entitled to Compensation

Name	Date of Birth	Mailing Address	Relationship to Officer

15. Has Application Been Made for Compensation, Annuity, or Other Benefits as a Result of This Death Under Any Compensation Law, Police Death or Survivor's Benefit Fund, or Other Such Fund? ☐ Yes ☐ No If Yes, Give Name and Address of Organization With Which Application Was Filed.

16. Was Officer Ever in the Armed Forces of the United States? ☐ Yes ☐ No If Yes, Furnish →	A. Service Number	B. Branch of Service	C. Period of Service From Through
17. If Question 16 is Answered "Yes," Has Application Ever Been Made for Compensation or Pension on Account of Such Service? ☐ Yes ☐ No If Yes, Furnish →	A. Claim Number	B. Name and Address of Office Where Claim is Filed	
18. Has Application Ever Been Made for Any Annuity on Account of Officer's Civilian Service With the United States? ☐ Yes ☐ No If Yes, Furnish →	A. Type of Annuity (e.g., civil service retirement)	B. Claim Number	

19. I hereby make claim for compensation for the spouse and/or children listed above, under 5 U.S.C. 8101 et seq., as extended by 5 U.S.C. 8191, as a result of the death of the above-named officer, who sustained fatal injury while in the performance of duty. Every statement set forth above is true to the best of my knowledge and belief.

(Signature of Claimant) (Date)

Claim on Behalf of Dependent Other Than Widow, Dependent Widower, or Children

1. Last, First, Middle Name of Deceased Officer

2. Date of Death (month, day, year)

3. Name of Officer's Former Employing Organization

4. Nature of Injury Which Caused Death

5. Last, First, Middle Name of Dependent

6. Dependent's Mailing Address Including ZIP Code

7. Dependent's Birth Date

8. Dependent's Social Security Number

9. Relationship to Officer

10. Dependency on Officer ☐ Total ☐ Partial

11. Amount Contributed by Officer Toward Dependent's Support During the 12 Months Immediately Prior to Death

12. Did Officer Live With Dependent During the 12 Months Immediately Prior to Officer's Death? ☐ Yes ☐ No If Yes, Furnish →

A. Amount Paid by Officer to Dependent in Money or Service for Room and Board in Addition to Contribution Shown in Item 11.

B. If No Fixed Amount Was Paid for Room and Board, What is the Fair Value of Such Room and Board?

13. Was Dependent Employed During the 12 Months Immediately Prior to Officer's Death? ☐ Yes ☐ No If Yes, Furnish →

A. Occupation (s)

B. Period Employed

C. Monthly Rate of Pay

14. In Addition to Employment, State Other Income From All Sources During the 12 Months Prior to Officer's Death.

Investments $ Pensions $ From People Other Than Officer $ All Other Sources $

15. At Time of Officer's Death Was Dependent Married? ☐ Yes ☐ No If Yes, Furnish →

A. Birth Date

B. Occupation

C. Total Income From All Sources For 12 Months Prior to Officer's Death

D. Monthly Rate of Pay

16. List All Property Owned by Dependent and/or Spouse (omit clothing, furniture). Give Approximate Market Value of Each Item and Date Acquired

17. List Name and Relationship of Persons Dependent Upon This Dependent.

18. Has Application Been Made for Compensation, Annuity, or Other Benefits as a Result of This Death Under Any Compensation Law, Police Death or Survivor's Benefit Fund, or Other Such Fund? ☐ Yes ☐ No If Yes, Give Name and Address of Organization With Which Application Was Filed.

19. Was Officer Ever in the Armed Forces of the United States? ☐ Yes ☐ No If Yes, Furnish →

A. Service Number

B. Branch of Service

C. Period of Service From Through

20. Has Application Ever Been Made for Any Annuity on Account of Officer's Civilian Service With the United States? ☐ Yes ☐ No If Yes, Furnish →

A. Type of Annuity (e.g., civil service retirement)

B. Claim Number

21. I hereby make claim for compensation under 5 U.S.C. 8101 et seq., as extended by 5 U.S.C. 8191, as a result of the death of the above-named officer, who sustained fatal injury while in performance of duty. Every statement set forth above is true to the best of my knowledge and belief.

(Signature of Claimant) (Date)

Form CA-722c
Rev. Mar 2010

INSTRUCTIONS FOR COMPLETING THIS FORM

(Please do not detach)

1. GENERAL. This form is used to report a death sustained by a non-Federal law enforcement officer under circumstances involving a crime against the United States. Specifically, section 8191 of title 5, United States Code, provides Federal workmen's compensation benefits for a person determined to have been on any given occasion -

(1) a law enforcement officer and to have been engaged on that occasion in the apprehension or attempted apprehension of any person

(A) for the commission of a crime against the United States, or

(B) who at that time was sought by a law enforcement authority of the United States for the commission of a crime against the United States, or

(C) who at that time was sought as a material witness in a criminal proceeding instituted by the United States; or

(2) a law enforcement officer and to have been engaged on that occasion in protecting or guarding a person held for the commission of a crime against the United States or as a material witness in connection with such a crime; or

(3) a law enforcement officer and to have been engaged on that occasion in the lawful prevention of, or lawful attempt to prevent, the commission of a crime against the United States;

and to have sustained a personal injury (including disease) resulting in death, related to that occasion. Federal law enforcement officers are excluded from section 8191.

If one of the above conditions is met, this form should be filed with the Office of Workers' Compensation Programs if there are survivors eligible for benefits or if there are any unpaid medical, funeral, or transportation bills. The form is designed so that if there are no eligible survivors who wish to file claim, then their portion of the form may be detached.

If additional space is needed for any answer, attach a separate sheet of paper and write, "see separate sheet," in the appropriate box of this form. Please place the name of the deceased officer (and case file number if known) to OWCP within 5 years from the date of death. If there are no survivors, it is suggested that their portion of this form be completed before the former employing organization and the physician complete their portion.

2. EMPLOYING ORGANIZATION'S REPORT. This report must be completed in every instance by the deceased officer's former employing organization. Wage information, duty hours, and like information should be obtained from the organization's records. If the organization disagrees with one or more of the statements made by the survivors, it should submit a detailed explanation giving the reasons for its disagreement.

3. ATTENDING PHYSICIAN'S MEDICAL REPORT. This report is to be completed by a physician who examined or treated the deceased officer. It is not necessary if a copy of a more complete medical report is being submitted.

4. CLAIM ON BEHALF OF WIDOW, WIDOWER, OR CHILDREN. This is a formal claim for death benefits on behalf of all those listed in the claim, it may be submitted by -

(1) any survivor of the deceased officer;

(2) any guardian, personal representative, or other person legally authorized to act on behalf of the officer's estate or any of his survivors; or

(3) any association of law enforcement officers acting on behalf of the officer's survivors.

Items 6 through 11 on this claim pertain to the surviving spouse and should not be completed if no claim is being made on his or her behalf, or if there is no surviving spouse. Item 12 asks for names of surviving children. If there are more children than room to enter their names, attach a separate sheet. This is very important. In the last line of item 12 write, "see attached sheet for names of additional children."

In item 14 list anyone else for whom the officer was furnishing some support at the time of his/her death. Include minor children from his/her prior marriages even though the officer was not supporting them prior to his/her death. Again, if more room is needed attach a separate sheet.

The form and the attachments (please read paragraph 6 below) should be sent to the officer's former employing organization.

5. CLAIM ON BEHALF OF DEPENDENT OTHER THAN WIDOW WIDOWER, OR CHILDREN. This is a formal claim for death benefits on behalf of one person. If more than one person listed below was dependent on the deceased officer, write to the Office of Workers' Compensation Programs for extra forms. This claim may be submitted by -

(1) any survivor of the deceased officer;

(2) any authorized to act on behalf of the officer's estate or any of his survivors; or

(3) any association of law enforcement officers acting on behalf of the officer's survivors. Those dependents other than the widow, widower, and children who may be eligible for benefits include dependent parents, dependent grandparents, dependent brothers, dependent sisters, and dependent grandchildren of the officer. There is no provision in the law for other relatives.

The form and the attachments (please read paragraph 6 below) should be sent to the officer's former employing organization.

6. ATTACHMENT. There are several documents that must be submitted in support of most claims. Sometimes they will not be readily available. To avoid delays in processing this form, make up a list of those documents that will be sent at a later date. Then as documents are received send them directly to the Office of Workers' Compensation Programs.

Needed are:

(1) Officer's death certificate (all cases);

(2) Birth certificates of all children claiming compensation; for adopted children furnish orders of adoption instead of birth certificates.

(3) Marriage certificate of spouse claiming compensation:

(4) Documents showing dissolution of prior marriages of officer and of spouse, such as final divorce decrees, death certificates (needed only if spouse is claiming compensation);

(5) Officer's birth certificate (needed only if claim is being made by parent, grandparent, brother, or sister of officer);

(6) Dependent's birth certificate (needed only if claim is being made by brother, sister, or grandchild of officer);

(7) As proof of relationship to the officer a grandparent claiming compensation must provide the birth certificate of the officer's mother or father, as appropriate; a grandchild claiming compensation must provide the birth certificate of the officer's son or daughter, as appropriate;

(8) A recent medical report describing disability for unmarried dependents over age 18 who are basing their claim on mental or physical disability (needed only if claim is being made by widower, child, brother, sister, or grandchild); if this person is committed to a public institution merely state the name and address of the institution.

Except for (8), all documents must bear the signature and seal (imprint) of the public official having custody of such records. All documents or records originating in a court of law must bear the signature and seal (imprint) of the proper court official. Photostat copies are not acceptable unless they bear the actual signature and seal of the public official, not just a copy.

7. SUBMITTING THIS FORM. This form and available attachments should be turned over to the officer's former employing organization. The organization will have any remaining parts completed. Afterwards, it should review the form and attachments for completeness and to see that all signatures appear. If a report of investigation of any type was made on the death or the incident leading to death, a copy should be attached. When the form and any statements and attachments are ready for transmission, this instruction page should be removed. Only one copy of this form (the original) need be submitted.

Privacy Act

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, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) 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 retention, rehire, or other relevant matters. (4) Information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) 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. (7) Disclosure of claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory. 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. (8) Completion of this form is voluntary; however, 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.

Note: This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the FECA.

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All completed forms, documents, and inquiries should be sent to
OWCP, Dist Office 9, Cleveland
1240 East Ninth Street, Room 851
Cleveland, Ohio 44199