File Number: «CaseNumber»
«FORM»-«CAT»-«SUBJ»

OMB No: 1240-0016
Expiration Date: XX-XX-XXXX

U.S. DEPARTMENT OF LABOR

«SenderAddress»
«Phone: «SenderPhone»

«Date»

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. Accordingly, you **must** report to OWCP any improvement in your medical condition, any employment, any change in the status of claimed dependents, any third party settlement, and any income or change in income from Federally assisted disability or benefit programs.

You must completely answer all questions and return this statement within 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 ANSWER 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 ALSO RESULT IN CRIMINAL PROSECUTION OR CIVIL ACTION FOR FALSE CLAIMS. 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.

Sincerely,

«SignatureName»
«SignatureTitle»

Enclosure(s): EN1032 (6 pages)

«CCAddresses»

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The authority for requesting this information is 5 U.S.C. 8101 et seq. The information will be used to determine continuing entitlement to benefits. Furnishing the requested information is required for the claimant to obtain or retain a benefit. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974, as amended (5 U.S.C. 552a). Failure to furnish the requested information may delay the process, or result in an unfavorable decision or a reduced benefit.

PUBLIC BURDEN STATEMENT

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control 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 and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this estimate or any other aspect of this information collection, including suggestions for reducing this burden, please send them to the Department of Labor, Office of Workers' Compensation Programs, Room S-3229, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

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, 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 healthcare 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 the claimant's social security number (SSN) on this form is mandatory. The SSN, 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) 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.

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CA-1032 (Rev.08-10)

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. Please note that you must report any employment held at the time of injury if you have worked at that employment during any period covered by this form.

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 or passive investment in any publicly traded businesses.

If you have questions about whether something is material or relevant and should be included, please list that information.

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: _____

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PART A—EMPLOYMENT (Continued)

b. If yes, state:
Dates of self-employment or involvement in business enterprise: _____
_____
Description of work or business involvement: _____
_____

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 including 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 and include a description of that work:_____
_____

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 augmented 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

PART C—DEPENDENTS (Continued)

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 support. YOU MAY NOT CLAIM OR RECEIVE AUGMENTED COMPENSATION FOR AN EX-SPOUSE EVEN IF YOU HAVE BEEN ORDERED TO PROVIDE SUPPORT IN THE FORM OF ALIMONY.

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: _____

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. You are required to report any changes in dependents as soon as those changes occur. 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.

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

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: _____
_____

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? This

includes any product liability or medical malpractice settlement/award you have received that relates to treatment for your accepted injury or illness. Yes or No: _____

PART E--THIRD PARTY SETTLEMENT (Continued)

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-- FRAUD 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, or date of injury 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: _____
_____

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 know that fraudulently concealing or failing to report income or other information in claiming payment or benefit under FECA may result in the forfeiture of compensation for the period covered by this form and may

also result in a civil action against me for damages under the False Claims Act or other applicable laws.

I understand that I must immediately report to OWCP any employment or employment activity, any

PART H—CERTIFICATION (Continued)

change in the status of claimed dependents, any third party settlement, and any monies or income or change in monies or 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	

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