SEPTEMBER 11TH VICTIM COMPENSATION FUND
ELIGIBILITY AND COMPENSATION FORM
FOR DECEASED INDIVIDUALS

COMPENSATION FORM
(Parts V-XI)

PART V. DECEDENT'S MEDICAL EXPENSE LOSS OR OTHER OUT-OF-POCKET EXPENSE LOSS (IF APPLICABLE)

Please complete this Part only if you are claiming past medical expenses or other out-of-pocket losses on behalf of the Decedent.

A. DECEDENT'S MEDICAL EXPENSE LOSS

- Does the Personal Representative seek compensation for the Decedent's incurred medical expenses that were not reimbursed and that were directly related to the treatment of the condition(s) listed in Part III? Yes/No.

  - If no, proceed to Part V.B

  - If yes, what is the nature and amount of these medical expenses? Expenses can include rehabilitation treatment, vocational training, home modification, prescription drugs, assisted living and other such expenses. Please itemize the type of medical service identified and the amount of expenses incurred for each type of medical service. You must submit documentation of any claimed medical expenses loss – for example, invoices or receipts from the health provider showing payments received.

Type of Medical Expenses Provider	Amount
	$
	$
	$
	$
	$
	$
TOTAL	$

- Did the Decedent have any insurance, health care or disability benefits under which the Decedent was covered for any period in which medical expenses are being claimed? Yes/No.

- If no, proceed to Part V.B

- If yes, please provide documentation of any reimbursement and/or coverage provided to Decedent for the condition that you seek compensation for from the VCF. If reimbursement and/or coverage was denied by any health insurer or other benefit provider, please submit documentation of the denial.

- Please identify the Decedent's coverage and/or eligibility at the time in which medical expenses are being claimed:

Insurance Type	Name of Carrier and Contact Information	Group or Individual	Policy or ID# if applicable
Major Medical		Group ☐ Individual ☐	
Union Benefits		Group ☐ Individual ☐	
Medicare			
Medicaid			
Disability Income Insurance		Group ☐ Individual ☐	
Workers' Compensation			
Other (please describe)			
Other (please describe)			
Other (please describe)			
Other (please describe)			

B. DECEDENT'S OTHER OUT-OF-POCKET EXPENSE LOSS

o Does the Personal Representative seek compensation for any other (non-medical) out-of-pocket expenses that the Decedent's incurred prior to death that were directly attributable to the Decedent's injury/condition from the September 11, 2001 terrorist attacks or debris removal? Yes/No.

- If no, proceed to Part VI

- If yes, please describe other out-of-pocket expense losses – i.e., expenses directly related to the condition for which compensation is sought.

_____

_____

_____

PART VI. **NON-REIMBURSED BURIAL AND MEMORIAL SERVICE COSTS**

Non-reimbursed burial and memorial service costs may be factored into the award calculation.

- Does the Personal Representative seek compensation for any out-of-pocket burial or memorial service expenses? Yes/No

    - If yes, please complete the following and submit supporting documents.

        Amount of non-reimbursed burial or memorial service costs: _____

PART VII. – DECEDENT'S LOSS OF EARNINGS/LOSS OF REPLACEMENT SERVICES

A. DECEDENT'S EMPLOYMENT HISTORY AND COMPENSATION/BENEFITS INFORMATION

Please complete the following information separately for Decedent's employment (i.e., different employer or different position/job title) for the period beginning three calendar years prior to the decrease in the Decedent's earnings capacity as a result of the Decedent's injury or condition and up to the year of Decedent's death. For example, if the Decedent was unable to continue working full time in his or her job after May 2008, please provide history starting in 2005. If self-employed for all or part of this period, please indicate that below where asked and provide the information requested. If the Decedent was unemployed for any part of this period, please indicate that below. (If you are submitting a hard copy claim form please make copies of this Section A and submit a copy of this section for each separate employment).

Note: **The VCF will need to receive documentation demonstrating the amounts and details of Decedent's compensation and benefits during this period.**

- Compensation includes base salary and wages as well as other sources of earned income such as commissions, bonuses, incentive pay, etc. Please note that passive sources of income, such as income from rental properties or investments, are not compensation for purposes of the VCF. Also note, that any compensation award for loss of future earnings will be based on certain employment benefits provided to the Decedent by his/her employer. Please see the Document Checklist and Instructions for further information.
- The Special Master recognizes that collecting this information may be a difficult task and will seek to work with the Decedent's employer to obtain and confirm compensation and benefits and make sure they have been calculated correctly.
- You also must submit copies of all tax return information (including W-2 forms and other attachments) for the period beginning three years prior to the decrease in the Decedent's earnings capacity as a result of the Decedent's injury or condition and up to the year of the Decedent's death.

Employment (complete separately for each job/position)

- Date Range: _____ to _____
- Job title/description: _____
- Please check the box that best describes the Decedent's annual income (including all forms of income) *during the last year of full-time work*.

☐ Under $25,000
☐ $25,000-$50,000

☐ $50,001-$100,000
☐ $100,001-$150,000
☐ $150,001-$250,000
☐ Over $250,000

- ☐ Check here if unemployed
- ☐ Check here if self-employed
- ☐ Check here if not self-employed and provide the following information:

Employer Name: _____
Employer Address: _____
_____

Employer Phone number: _____
Employer Email: _____
Indicate how Decedent's base salary/wages were paid?

☐ Yearly ☐ Monthly ☐ Weekly
☐ Hourly ☐ Other. Specify._____

- Did Decedent receive other compensation including, but not limited to, incentive pay, bonuses, overtime, tips, commissions, shift differentials, longevity, and honoraria? Yes/No.

If yes, check any that apply:

☐ incentive pay	☐ bonuses
☐ overtime	☐ tips
☐ commissions	☐ longevity
☐ shift differentials	☐ honoraria
☐ other. Describe: _____	

Note: For Decedents who were in the armed forces – You should include information on housing, subsistence, TAD, re-enlistment, and other compensation by each category. However, if you want the Special Master to rely on published compensation and benefit scales please check the box at the end of this statement. If you do so, there is no need to provide information on this additional compensation, but please submit a copy of the Decedent's Military Leave and Earnings Statement indicating the pay level and benefit information.

☐ I wish to rely on published data regarding U.S. military compensation.

- Did Decedent receive health benefits?
  - ☐ Yes, throughout course of employment
  - ☐ Yes, for portion of employment. Please specify dates._____
  - ☐ No

If yes, indicate who was covered:

☐ Decedent only
or
☐ Decedent and One Dependent
or
☐ Decedent and Family

- Did Decedent receive pension benefits?

☐ Yes, throughout course of employment
☐ Yes, for portion of employment. Please specify dates._____
☐ No

If yes, check one:

☐ Defined Benefit Plan (monthly pension payable at retirement)
Indicate Decedent's hire date at last employer: (_____/_____/____)

☐ Defined Contribution Plan (employer contribution each pay period)
Indicate employer contribution as % of salary: _____%

- Did employer provide matching contribution to a 401(k) or 403(b)?

☐ Yes, throughout course of employment
☐ Yes, for portion of employment. Please specify dates._____
☐ No

- Did employer provide a transportation subsidy or company car?

☐ Yes, throughout course of employment
☐ Yes, for portion of employment. Please specify dates._____
☐ No

If car was provided, please specify % of personal use: _____%

- Did employer provide club dues or memberships?

☐ Yes, throughout course of employment
☐ Yes, for portion of employment. Please specify dates._____
☐ No

If yes, indicate whether:

☐ Yearly ☐ Monthly
☐ Weekly ☐ Hourly
☐ Other. Specify._____

- Did employer provide a housing allowance (Non-military) (military allowances should be included on page ___)?

☐ Yes, throughout course of employment
☐ Yes, for portion of employment. Please specify dates._____
☐ No

If yes, indicate whether the allowance was:

☐ Yearly ☐ Monthly

☐ Weekly ☐ Hourly
☐ Other. Specify._____

Check whether the allowance was:
[ ] Permanent.
[ ] Temporary. If temporary, when did it end? _____

- Did the employer provide other benefits? Yes/No.
  If yes,
  Describe: _____

Indicate whether:

☐ Yearly ☐ Monthly
☐ Weekly ☐ Hourly
☐ Other. Specify._____

Describe: _____

Indicate whether:

☐ Yearly ☐ Monthly
☐ Weekly ☐ Hourly
☐ Other. Specify._____

B. DECEDENT'S EDUCATION HISTORY/ACCREDITATION HISTORY

Please provide information on the highest degree or accreditation earned by the Decedent (or the last year of schooling completed).

Year Earned (mm/dd/yyyy)	**Name and Address of Institution**	**Degree/Accreditation (e.g., BA, PhD, GED, Trade Certification)**

C. DEPENDENTS

- Did the Decedent have any dependents? Yes/No.

  - If no, proceed to Part VII.D

  - If yes, please submit a copy of the Decedent's Federal/National tax return (if one was filed) for the three years prior to the Decedent's death. Please list below any qualifying dependents that were **not** listed on the Decedent's most recent Federal/National Tax Return (such as children born or adopted on or after January 1 of the year of the Decedent's death or children listed on the spouse's separately-filed return) and explain their relationship to the Decedent.

Dependent's Name (First Middle Last)	Date of Birth (mm/dd/yyyy)	SSN or National ID Number	Relationship to Decedent

D. LOSS OF EARNINGS PRIOR TO DEATH

- Do you claim any loss of earnings prior to the Decedent's death? Yes/No.
  - If no, proceed to Part VII.E
  - If yes,
    - (1) Describe the amount of time the Decedent missed work as a result of his/her injury or condition (i.e. work missed for which the Decedent was not compensated).

      _____

      _____
    - (2) Describe any loss of earnings and/or other benefits from work missed as a result of the Decedent's injury prior to his/her death (i.e. work missed for which the Decedent was not compensated). You will need to submit documentation regarding the Decedent's uncompensated absences from work as a result of injury sustained as a result of the September 11th air crashes or debris removal.

      _____

      _____

E. REPLACEMENT SERVICES (IF APPLICABLE)

Replacement services loss represents the value of household services the Decedent provided to the household prior to his or her death. Please refer to the Instructions for information on whether and to what extent the VCF will consider replacement services loss in calculating economic loss.

- Do you claim any replacement services loss for the Decedent? Yes/No.
  - If no, proceed to Part VIII
  - If yes,

- (1) Identify the specific household services that the Decedent performed prior to death.

  _____

  _____

- (2) Describe the costs of any replacement services incurred to date. You will need to submit documentation regarding any replacement services costs.

  _____

  _____

- (3) Describe the cost/value of replacement services (on an hourly, monthly or annual basis) expected to be incurred in the future.

  _____

  _____

PART VIII. COLLATERAL SOURCE PAYMENTS

In this Part, please identify any compensation or benefits the Decedent or the Decedent's beneficiaries or estate received or is entitled to receive from other sources as a result of the terrorist–related aircraft crashes of September 11, 2001 or debris removal efforts. For example, if the Decedent received insurance or a specific payment from an employer that is not part of the normal compensation, these might be considered "collateral source" payments. Under the statute, the Special Master is required to reduce the compensation award by the amount of collateral source compensation a Decedent or a Decedent's beneficiaries or estate has received or is entitled to receive as a result of the terrorist-related aircraft crashes of September 11, 2001 or debris removal efforts. *Note*: Settlement payments from September 11th-related lawsuits are to be included in Part I.E. and do not need to be listed again in this Part

A. LIFE INSURANCE (INCLUDING ACCIDENTAL DEATH AND MORTGAGE INSURANCE) PAID OR TO BE PAID AS A RESULT OF THE DECEDENT'S DEATH.

Insurance Carrier/Provider	Account/Policy Number	Beneficiary(ies) and Relationship to Decedent	Amount (by beneficiary)	Amount of Decedent's Investment Portion or Premiums Paid (if applicable)

B. DEATH BENEFIT PROGRAMS

- Have the Decedent's beneficiaries received any benefits from a Death Benefit Program as a result of the death of the Decedent (other than insurance and charitable contributions). For example, Public Safety Officer Benefit payments or Dependency and Indemnity Compensation. Yes/No

  - If yes, please identify and describe below and submit supporting documentation on the program such as a program description.

_____
_____
_____

C. PENSIONS

- Are there any pension claims in which the Decedent was a participant? Yes/No

- If yes, please specify the part of the pension that was paid or is payable because of death and the amount vested or payable to the Decedent prior to death. Submit supporting documentation on the pension plans, such as a plan description and statement.

_____
_____
_____

D. SOCIAL SECURITY AND WORKERS' COMPENSATION PROGRAMS

- Have the Decedent's beneficiaries received or are the Decedent's beneficiaries receiving any payments from the Social Security Administration or from workers' compensation programs as a result of the Decedent's death? (Include uniformed service benefits similar to Social Security or workers' compensation). Yes/No.

  - If no, have the Decedent's beneficiaries applied to receive payments from the Social Security Administration or from workers' compensation programs as a result of the Decedent's death? Yes/No

    - If yes,

      - Identify program or benefit applied for: _____

      - Was the application denied? Yes/No

      - Is the application pending? Yes/No - Submit any pending applications

  - If yes, please identify and describe any payments that the Decedent's beneficiaries have received or are receiving and submit rulings, orders, determinations, or correspondence from the Social Security Administration or workers' compensation program.

_____
_____
_____

E. MEDICAL PAYMENTS

- Did the Decedent receive any medical payments prior to the Decedent's death for physical injuries or conditions that the Decedent sustained as a direct result of the terrorist-related aircraft crashes of September 11, 2001 or debris removal efforts? Yes/No

- If no, proceed to Section VIII.F
- If yes,
    - Please identify and describe medical payments and submit documentation of such payments.

_____
_____
_____

F. OTHER PAYMENTS

- Have the Decedent's beneficiaries received any other payments as a result of the Decedent's death (excluding charitable contributions)? Yes/No.
    - If yes, please identify and describe and submit any documentation of such payments.

_____
_____
_____

PART IX. INFORMATION REGARDING WILL AND PROPOSED DISTRIBUTION PLAN

Did the Decedent leave a will? Yes ☐ No ☐

If yes, has the will been probated? Yes ☐ No ☐

Please list the beneficiaries of the Decedent's will and their percentage if it can be determined:

Beneficiary Name (First Middle Last)	Percentage of Estate

Below, please provide information on how you propose to distribute the award. The distribution must be consistent with the law of the Decedent's state of domicile or any applicable ruling made by the court of competent jurisdiction. The Special Master anticipates that in many cases a portion of the award may be distributed in accordance with the wrongful death laws of the Decedent's state or country, although this will not be the case universally. Please refer to the instructions and FAQ's for more information on the distribution plan. Note that any proposed distribution plan will be affected by offsets and any final plan must be reviewed by the Special Master.

Relationship to Decedent	Name and Address	Telephone Number	SSN or National ID Number	Date of Birth	% of Economic Award
Spouse					
Child					
Child					
Child					
Mother					
Father					
Sibling					
Other (specify)					
Other					

Relationship to Decedent	Name and Address	Telephone Number	SSN or National ID Number	Date of Birth	% of Economic Award
(specify)					

PART X. OTHER INFORMATION (OPTIONAL)

Please use the area below (and any additional pages) to provide any other information that you believe may be relevant to the individualized circumstances of your claim and the calculation of the economic and non-economic loss as well as collateral offsets. You may also submit any additional documents not already requested that you believe might be relevant.

PART XI. CERTIFICATION FOR COMPENSATION FORM

A. PRIVACY ACT NOTICE

The Department of Justice is authorized to collect this information by the September 11th Victim Compensation Fund of 2001, Title IV of Public Law 107-42, Air Transportation Safety and System Stabilization Act, 49 U.S.C. § 40101 note, as amended by the James Zadroga 9/11 Health and Compensation Act of 2010, Title II of Public Law 111-347. The information you submit in your claim is for official use by the U.S. Department of Justice for the purposes of determining your eligibility for and the amount of compensation you may receive under your claim to the Victim Compensation Fund. Provision of this information is voluntary; however, failure to provide complete information may result in a delay in processing or a denial of your claim. Information you submit regarding your claim may be disclosed by the Government only in accordance with the provisions of the Privacy Act.

I Authorize the U.S. Department of Justice to disclose any records or information relating to my Victim Compensation Fund claim for the purpose of determining qualification and/or compensation of my claim to: agency contractors assisting in the administration of the Victim Compensation Fund; other federal, state, or local agencies, including the Department of Treasury and NIOSH; and other individuals or entities having information related to the claim, such as physicians, medical service providers, insurers, and employers.

B. CERTIFICATION OF ACCURACY OF INFORMATION

I hereby certify that the information provided in this application and any documents provided in support of this claim are true and accurate to the best of my knowledge, and I agree that any payment made by the VCF is expressly conditioned upon the truthfulness and accuracy of the information and documentation provided in support of the claim. Further, I understand that false statements or claims made in connection with this application may result in fines, imprisonment and/or any other remedy available by law to the Federal Government, and that suspicious claims will be forwarded to federal, state, and local law enforcement authorities for possible investigation and prosecution.

I declare under penalty of perjury that the foregoing is true and correct. Executed on this _____ day of _____, 201_.

Signature of Personal Representative

C. CERTIFICATION OF DISTRIBUTION PLAN

I hereby agree to distribute any award in a manner consistent with the law of the Decedent's domicile or any applicable ruling by a court of competent jurisdiction or as directed by the Special Master. I understand that the final distribution plan may differ from the plan proposed in Part IX.

Initial here: _____

D. PAPERWORK REDUCTION ACT NOTICE

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it contains a currently valid OMB approval number. We try to create forms and instructions that are accurate, can be easily understood, and that impose the least possible burden on you. The estimated average time to complete and file this application is [ ]. If you have comments regarding the accuracy of this estimate, or suggestions for making this form simpler, you can write to the Office of the Special Master, U.S. Department of Justice, 950 Pennsylvania Ave, NW, Washington, DC 20530; OMB control number 1105-_ _ _ _ . (Do not mail your completed application to this address.)