U. S. DEPARTMENT OF LABOR

OMB NO: 1240-0013
Expiration Date: XX-XX-XXXX

«SenderAddress»
Phone: «SenderPhone»

«Date »

Date of Injury: «DtInjury»
Employee: «ClaimantFullName»
Dep(s): «Dependent1»
«Dependent2»
«Dependent3»
«Dependent4»

«ToAddress»

Dear «Salutation»:

To help us reach a decision regarding a claim for compensation filed by «ClaimantFullName», please furnish the information requested below. This information is required to obtain or retain a benefit (5 U.S.C. 8101 et seq.).

1. State your relationship to employee (that is, wife, husband, natural parent or guardian of dependent(s) named above, or parent of employee).

_____

2. State the amount of money that employee regularly contributes to your support or to the support of the dependent(s) named above. State how often the contributions are made – weekly, monthly, etc. If contributions are not made at regular intervals or in the form of money, please explain.

_____

_____

_____

_____

If you have a disability (a substantially limiting physical or mental impairment), please contact our office/claims examiner for information about the kinds of help available, such as communication assistance (alternate formats or sign language interpretation), accommodations and modifications.

3. Approximate date such contributions were first made:

_____

4. If you are natural parent or legal guardian of the dependent(s) named above, give the age and relationships to the employee of each dependent.

_____

_____

5. If you are a parent of the employee, state the source and amount of all your other income. If none, so state.

_____

_____

I certify that each and every statement made above is true to the best of my knowledge. I further understand that any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

_____ _____

Signature Date

Sincerely,

«SignatureName»
«SignatureTitle»

«CCAddresses»

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 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. 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 aspect of this collection of information, including suggestions for reducing this burden, to the Office of Workers' Compensation Programs, Department of Labor, Room S-3229, 200 Constitution Avenue, NW, Washington, DC 20210, and reference the OMB Control Number 1240-0013. Note: please do not send the completed form to this office; rather, send it to the address shown on the letterhead.