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OMB No: 1240-
0013

Expiration Date: XX-XX-XXXX

U.S. DEPARTMENT OF LABOR

«SenderAddress»
Phone: «SenderPhone»

«Date»

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

«ToAddress»

Dear «Salutation»:

Compensation may continue to be paid on behalf of an unmarried child age 18 or older who is either a full-time student or incapable of self-support. We need additional information to determine whether «usr_CHILD_NAME» has continuing eligibility for compensation beyond the eighteenth birthday.

«usr_OPTIONAL_PARAGRAPHS_1»

The law prohibits the acceptance of compensation when a dependent is no longer entitled to it. If the dependent is «usr_OPTIONAL_PARAGRAPHS_NNL_2»

Any compensation payment you receive after such a change in status of the dependent must be returned to this office for cancellation. It will be replaced with a payment in the correct amount.

Sincerely,

«SignatureName»
«SignatureTitle»

Enclosures

«CCAddresses»

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.

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 is estimated to average to vary from 15 to 45 minutes per response with an average of 30 minutes per response, including the time for reviewing data needed, and completing and reviewing the 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.

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PART A- TO BE COMPLETED BY CLAIMANT

1. Name of dependent for whom you claim compensation:_______________________

2. Date of dependent's birth:__________

3. Dependent's Social Security Number:________________

4. Has the dependent completed four years of education beyond high school?____

5. Has the dependent married? ____ If so, give the date of marriage._______________

6. Is the dependent now attending school on a full-time basis? ____
If so, on what date did attendance at this school begin? _________________

7. Have you applied for educational benefits for this dependent from the Department of Veterans Affairs (VA)?____

If so, have you received educational benefits from the VA?____ Date benefits began: _____

I certify that the information given by me on this questionnaire is true, correct, and complete to the best of my knowledge. Any information left blank on this form has been done intentionally and indicates I had no information to provide for that question. I understand that any false statement, misrepresentation, or concealment of fact, in respect to this claim, may be grounds for forfeiture of compensation benefits and could subject me to civil liability or, if fraudulent, may result in criminal prosecution.

Signed____Date_____________________

Address____

(Street) (City) (State) (Zip)

:

PART B- TO BE COMPLETED BY SCHOOL OFFICIAL

Please refer to the accompanying Part A.

1. Is «usr_CHILD_NAME» currently enrolled in your institution fulltime?

2. Name and address of educational institution:

3. What are the beginning and ending dates of the present school year?

4. When should this student expect to complete the present course of study?

5. Is your school an accredited or licensed institution?

I have reviewed Part A and I certify that the information given by me on this questionnaire is true, correct, and complete to the best of my knowledge.

Signed____

Title____

Date____

Return Parts A and B together to the following address:

U.S. Department of Labor
DFEC Central Mailroom
P.O. Box 8300
London, KY 40742-8300