U. S. DEPARTMENT OF LABOR

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

«SenderAddress»
Phone: «SenderPhone»

«Date»

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

«ToAddress»

To the Estate of «ClaimantFullName»

Dear «Salutation»:

On behalf of the Office of Workers' Compensation Programs, please accept our condolences on the death of «ClaimantFullName». It appears that additional money was due at the time of the death.

Before we can determine the amount due or to whom it should be paid, all uncashed compensation checks must be returned to this office. Also, the enclosed questionnaire should be completed by the administrator of the estate, if one has been appointed. Otherwise, the next of kin should complete it. The completed form should be sent to this office with a copy of the death certificate.

Unnecessary delays may be avoided if the information requested is furnished promptly and all payments made after the date of death are returned. If you have any questions or require any assistance, please contact this office.

Sincerely,

«SignatureName»
«SignatureTitle»

Enclosure: Questionnaire

«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.

DeathCompDue

Revised January 2013

QUESTIONNAIRE FOR COMPENSATION DUE AT DEATH

1. Name of the Deceased/Claim Number:

2. Date of Death:

3. Give the following information about relatives of the deceased who may be entitled to share in distribution of the estate:

Name Birth Date Relationship Address, City, State, Zip Phone

_____/ _____/ _____/ _____

_____/ _____/ _____/ _____

_____/ _____/ _____/ _____

_____/ _____/ _____/ _____

4. If an administrator or executor has been appointed, give their name and address; attach a copy of the appointment document.

_____

_____

_____

5. Did the deceased die intestate (that is, having made no will)?

6. Name, address and telephone number of person completing this form:

7. Relationship of person completing this form to deceased:

I hereby certify that each and every statement made above is true and complete to the best of my knowledge and belief. I 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.

Signed:_____ Date:_____

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 be average 30 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.