Month, Day, Year

Name
Address
City, State ZIP

File Number:
Payee Name:
Payee SSN:

Dear Mr. / Ms. Claimant:

I am pleased to inform you that your claim for benefits under the Energy Employees Occupational Illness Compensation Program Act of 2000 (EEOICPA) has been approved in the amount of: **$*********

Enclosed is the EN-20 Payment Information form which you, your legal guardian, or the person with power of attorney to act for you must complete, sign and return to the Division of Energy Employees Occupational Illness Compensation district office handling your claim. The person completing the EN-20 must submit it with an original signature; we cannot accept faxes or other copied versions of the EN-20. The form must also be completed in permanent ink and there can be no cross outs, trace-over marks, or other marks. Any alteration of the form, including the use of white out or correction tape, will result in it being rendered unusable for purposes of issuing payment; this will cause a delay in processing your payment.

Please read the instructions carefully to avoid any delays. To ensure your money arrives promptly and to the correct account, check with your financial institution before submitting the form to verify **the accuracy of the routing number** and **your account number.**

The completed EN-20 should be returned within sixty (60) days of the date of this correspondence. **Failure to return the signed form within this period may be deemed a rejection of payment.** If you have questions about completing the EN-20 or you make a mistake or need another form, please contact your district office at (Insert Number).

Sincerely,

Printed Name
Title

Enclosure: EN-20

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 Energy Employees Occupational Illness Compensation Program Act (42 USC 7384 *et seq*.) (EEOICPA) 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 received will be used to determine eligibility for, and the amount of, benefits payable under EEOICPA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agencies or private entities that employed the employee to verify statements made, answer questions concerning the status of the claim and to consider other relevant matters. (4) Information may be disclosed to physicians and other health care providers for use in providing treatment, performing evaluations for the Office of Workers' Compensation Programs, and for other purposes related to the medical management of the claim. (5) Information may be given to Federal, state, and local agencies for law enforcement purposes, to obtain information relevant to a decision under EEOICPA, to determine whether benefits are being paid properly, including whether prohibited payments have been made, and, where appropriate, to pursue debt collection actions required or permitted by the Debt Collection Act. (6) Disclosure of your social security number (SSN) or tax identification number (TIN) is mandatory. We are authorized to collect your SSN or TIN under Executive Order 9397 (November 22, 1943). Your SSN or TIN, 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. (7) 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.

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995, no persons are required to respond to the information collections on this form unless it displays a valid OMB control number. Public reporting burden for this collection of information is estimated to average 5 minutes per response, including time for reviewing instructions, searching existing data sources, gathering the data needed, and completing and reviewing the collection of information. The obligation to respond to this collection is required to obtain EEOICPA benefits (20 CFR 30.505). Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S3524, 200 Constitution Avenue N.W., Washington, D.C. 20210, and reference OMB Control No. 1240-0002 and Form EE/EN-20. **Do not submit the completed form to this address.**

OMB Control No. 1240-0002
EE-20
Expiration Date: XX/XX/20XX
April 2013

File Number: _____
Payee Name: _____
Payee SSN: _____

Authorized Payment

You have been found eligible to receive compensation in the amount of: $ _____

Authorizing Claims/FAB Examiner (signature): _____

Payment Information

If you choose to accept the authorized payment, you must provide all of the requested information and mail this form to the DEEOIC district office handling your claim within sixty (60) days from the date of this letter. Provide all of the financial institution and account information requested below. DEEOIC cannot accept wire numbers or issue EFT payments to brokerage firms or other financial institutions that have a third party routing system. Check with your financial institution before submitting the form to ensure an EFT can be made directly to your account and to verify the accuracy of all information provided in this section. Please print clearly.

Financial Institution Information

Name of Financial Institution: _____

Street Address: (P.O. Boxes not accepted) _____

City: _____ State: _____ Zip: _____

Telephone Number: ( ) _____

Account Information

Transfer funds to: (***check one***)

☐ Checking Account – provide checking account number: _____

☐ Savings Account – provide savings account number: _____

Names of ALL persons listed on the account: _____

Financial Institutions Nine (9) Digit Routing Number or ID#: | | | | | | | | | |

Certification

I hereby certify that I have reported to DEEOIC any third party settlement I have received, any tort suit I have filed against a beryllium vendor or an atomic weapons employer, any state workers' compensation awards I have received, any information I have regarding survivors (if applicable), and any conviction for fraud against this program or any other federal or state workers' compensation program. I affirm that the information provided on this form is true and that the method of payment is correct.

VERIFICATION STATEMENT FOR POWER OF ATTORNEY: I know that anyone who fraudulently conceals or fails to report information that 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 EEOICPA may be subject to criminal prosecution, from which a fine and/or imprisonment may result. As the power of attorney, my signature below serves to verify that, to the best of my knowledge and belief, the power of attorney I have to act on behalf of the above-named claimant is still valid under the existing law in the state in which the claimant executed the power of attorney, as of the date of my signature on the EN-20. I also affirm that the information provided on this form is true.

_____ ( ) _____
Printed Name — Current Telephone Number

_____ _____
Signature — Date

Instructions for Completing the EN-20

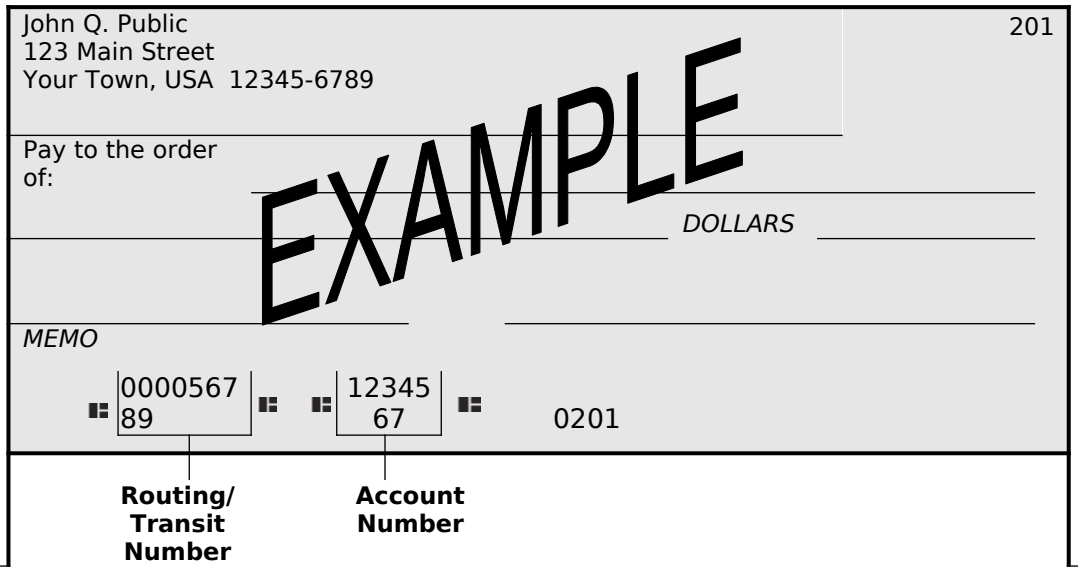
The EN-20 is used to collect financial information needed to pay compensation to an individual who has been found eligible for benefits under the Energy Employees Occupational Illness Compensation Program Act. This form is not to be completed if the named payee is deceased. Any change in the payee's status must be reported to the district office immediately. The beneficiary, his or her legal guardian, or the person with the power of attorney to act for the beneficiary, must complete the form in permanent ink. The requested information must be completed in its entirety. Any omission or alteration of the information will result in it being found invalid and another EN-20 will have to be completed. Contact the district office handling your claim if you have any questions or need assistance completing the form.

Authorized Payment

The amount of compensation to be paid is listed in this section. The signature of the claims examiner or Final Adjudication Branch (FAB) representative authorizing payment must be present.

Payment Information

List the name, telephone number and address for the financial institution processing the deposit. In the account information section, list the names of all persons listed on the account. The nine digit routing number and the account number should be clearly printed in the appropriate sections. Do not use a deposit slip for purposes of reporting a routing or account number; they do not necessarily contain valid routing numbers. You can obtain the routing number and checking account number off one of your personal checks. Below is an example of where to find these numbers. *However, to ensure the numbers are correct and to minimize any potential delays in paying your award, you should confirm all information reported in the EFT section with your bank or financial institution before submission.*



CERTIFICATION

If you have provided all the required information, print your name and sign and date the form. Submit the original EN-20 to the district office handling your claim. You may make copies of the form for your records. If you are signing this form with "power of attorney" and have not submitted the documents granting this authority, please submit them with the completed EN-20.

Most common reasons the form must be resubmitted:

- No original signature
- Faxed the form or submitted a copy
- Did not complete the form in permanent ink
- There are cross outs, trace-over marks, or other marks
- Use of white out or correction tape
- Incorrect routing or account numbers