Date: File Number:

Response requested

Name ☐ First Request
Address ☐ Second Request
City, State, ZIP ☐ Final Request

Dear Ms./Mr. :

This letter is in regard to your claim under Part E of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). Your claim has been accepted for the following illness(es): **List illness(es) and ICD-9 code(s)**. As such, you may be eligible for a monetary award for permanent impairment caused by the accepted illness(es).

"Whole body impairment" (or "impairment") is a percentage rating that represents the extent of impairment of a person based on the organ(s) and or system(s) affected by the accepted illness(es). The percentage of impairment reflects how severely your accepted illness(es) affect your body as a whole. The available monetary benefit is $2,500 for every percentage point, up to a maximum monetary award of $250,000 under Part E.

An impairment rating must be performed by an appropriate physician once your accepted illness has reached maximum medical improvement, meaning that it is unlikely to improve with additional treatment. In order for a physician to be considered able to perform impairment evaluations under EEOICPA, the physician must hold a valid medical license and Board certification (or eligibility) in an appropriate field of expertise. The physician must also be certified by the American Board of Independent Medical Examiners or the American Academy of Disability Evaluating Physicians, or possess the requisite professional experience and medical work background in interpreting the American Medical Association's *Guides to the Evaluation of Permanent Impairment (*AMA's *Guides*) to provide such ratings.

The impairment evaluation must be well-reasoned and performed in accordance with the Fifth edition of the AMA's

Guides, and include references to the pages and tables used in arriving at the impairment rating.

If you believe you may qualify and wish to claim impairment benefits, please complete the enclosed Form EN-11A and be sure to provide the following information:

- Check "**YES**" to indicate that you are seeking impairment benefits.
- Identify the accepted illness(es) (see the first paragraph of this letter) for which you are seeking impairment benefits.
- Check one of the two options to indicate who you would like to perform your impairment evaluation. If you decide to select your own physician to perform the impairment evaluation, the physician must demonstrate that he or she is qualified as noted above. For example, the physician may submit a statement identifying his/her specific expertise and knowledge of the AMA's *Guides* (*i.e.*, years performing ratings, experience in rating the given condition/body part).

If you elect not to pursue an impairment claim at this time, please check "**NO**" on Form EN-11A and we will not further develop the issue. Also, if this letter is marked above as a "Final Request" and we do not hear from you, we will also not develop this issue further. However, you retain the right to pursue an impairment claim in the future simply by notifying us in writing and sending it to the address at the bottom of the enclosed Form EN-11A.

We would appreciate receiving your written response within 30 days. If you have any questions regarding this letter or impairment benefits in general, please do not hesitate to contact me. You may call me at (xxx) xxx-xxxx.

Sincerely,

Claims Examiner

Enc: Pamphlet, *"How Do I qualify for an Impairment Award"*
EN-11A

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 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. (4) 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 15 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, send them 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-11A. **Do not submit the completed form to this address.**

OMB Control No: 1240-0002 EE-11A
Expiration Date: XX/XX/20XX April 2013

File No. - - - - - - -
Employee Name:

Impairment Benefits Response Form

☐ **YES,** I wish to pursue a claim for impairment benefits for the following accepted illness(es).

_____ _____

_____ _____

If you checked **YES** above, you must check one of the two options below and provide the necessary information:

☐ I want to have DEEOIC arrange for a qualified physician, known as a Contract Medical Consultant (CMC), to perform my impairment evaluation.

☐ I want to select my own qualified physician to perform my impairment evaluation. The physician's name, address and phone number is:

Physician Name:_____
Address: _____
_____
Phone No:( )_____

☐ **NO**, I am not pursuing impairment benefits at this time. I understand that I can file for impairment benefits in the future by submitting a signed statement to that effect to the district office.

Signature (Required)

_____ _____
Signature *Date*

Return this form to: US Dept. of Labor, OWCP/DEEOIC
(City) District Office
(Address 1)
(City, State, Zip)

Or you may fax it to: (xxx) xxx-xxxx

OMB Control No: 1240-0002 EN-11A
Expiration Date: XX/XX/20XX