

Date  
File Number:

Employee Name:

Telephone Number:

JOHN Q. CLAIMANT  
1111 MAIN STREET  
OAK RIDGE, TN 44444

Dear Mr. Claimant:

The information requested in the attached enclosure is required in connection with your claim for benefits under the Energy Employees Occupational Illness Compensation Program Act of 2000 (EEOICPA). This information will be used to decide if you are entitled to benefits, and if so, the level of benefits you may receive.

You must completely answer all questions and return the enclosure within 30 days of the date of this letter. Otherwise, the Division of Energy Employees Occupational Illness Compensation (DEEOIC) will not be able to process your claim for benefits under EEOICPA. Pub. L. 100-503 provides that the statements on the enclosure and other information in your claim file may be verified through computer matches. DEEOIC may also request that you submit any factual evidence it deems necessary to support your statements.

**READ ALL INSTRUCTIONS CAREFULLY BEFORE FILLING OUT THE ENCLOSED EN-16. YOU MUST ANSWER ALL OF THE QUESTIONS. IF THE QUESTION DOES NOT APPLY TO YOUR CLAIM, STATE "NOT APPLICABLE (N/A)" OR "NONE."**

If you need more space to fully answer any of the questions, use another sheet of paper with your name and claim number at the top. Sign and date each extra sheet.

**WARNING**

**A FALSE OR EVASIVE ANSWER TO ANY QUESTION, OR THE OMISSION OF AN ANSWER, MAY BE GROUNDS FOR FORFEITING YOUR BENEFITS AND SUBJECT YOU TO CIVIL LIABILITY. A FRAUDULENT ANSWER MAY RESULT IN CRIMINAL PROSECUTION. ALL STATEMENTS ARE SUBJECT TO INVESTIGATION FOR VERIFICATION.**

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

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When you have completed the enclosure, **sign it and mail it to the address shown at the top of this letter.** You may also FAX the completed and signed EN-16 to (XXX) XXX-XXXX. Your signature certifies that you have supplied all information requested by the enclosure. If you have any questions about completing the enclosure, call or write the district office.

Sincerely,

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CLAIMS EXAMINER

Enclosure: EN-16

**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 20 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-16. **Do not submit the completed form to this address.**

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File Number:

Claimant:

PART A - TORT SUITS FILED AGAINST BERYLLIUM VENDORS OR ATOMIC WEAPONS EMPLOYERS

1. Have you filed a tort suit (other than an administrative or judicial proceeding for workers' compensation) against a beryllium vendor or atomic weapons employer related to an exposure for which you would be eligible to receive compensation under EEOICPA? Yes or No:

\_\_\_\_\_

2. If Yes, state:

Date of filing: \_\_\_\_\_  
Party or parties involved: \_\_\_\_\_  
Date tort suit was dismissed: \_\_\_\_\_

List any other tort suits on an extra sheet.

PART B - THIRD PARTY SETTLEMENTS OR AWARDS

1. Have you received any settlement or award from a claim or suit (other than a claim for workers' compensation) against a third party (other than a beryllium vendor or atomic weapons employer listed in Part A above) related to an exposure for which you would be eligible to receive compensation under EEOICPA? Yes or No: \_\_\_\_\_

2. If Yes, state:

Date of judgment or settlement: \_\_\_\_\_  
Party or parties involved: \_\_\_\_\_  
Type of suit or settlement: \_\_\_\_\_  
Amount of award or settlement: \_\_\_\_\_

List any other third party settlements or awards on an extra sheet.

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PART C - STATE WORKERS' COMPENSATION

1. Have you filed for or received any state workers' compensation benefits on account of your claimed illness(es)? Yes or No: \_\_\_\_\_

2. If you answered "Yes," please tell us the following information:

Date of filing: \_\_\_\_\_

State in which you filed: \_\_\_\_\_

Illness(es) for which you received benefits: \_\_\_\_\_

Name of employer, insurer or state that paid: \_\_\_\_\_

Amount of monetary benefits received: \$ \_\_\_\_\_

Type of benefits (disability, impairment, etc.): \_\_\_\_\_

PART D - FRAUD CHARGES

1. Have you either pled guilty to or been convicted on any charges of having committed fraud in connection with an application for or receipt of benefits under EEOICPA or any other federal or state workers' compensation law? Yes or No: \_\_\_\_\_

2. If Yes, state:

Date of conviction or guilty plea: \_\_\_\_\_

Jurisdiction where fraud charges were brought: \_\_\_\_\_

PART E - SURVIVORS OF DECEASED EMPLOYEES

1. Are you claiming compensation under EEOICPA as a survivor of a deceased employee? Yes or No: \_\_\_\_\_

2. If Yes, state:

Your relationship to the deceased employee: \_\_\_\_\_

If spouse, list date and place of marriage: \_\_\_\_\_

If other than spouse, list your date of birth: \_\_\_\_\_

3. Do you know of any other persons who may also be eligible to receive compensation under EEOICPA as a survivor of the deceased employee upon whom your claim is based? Yes or No: \_\_\_\_\_

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4. If Yes, state:

Name of other survivor: \_\_\_\_\_  
Relationship of other survivor to deceased employee: \_\_\_\_\_  
Address and/or telephone number of other survivor (if known): \_\_\_\_\_

List any other survivors on an extra sheet.

PART F - CORRECTIONS

If the name, address, file number or telephone number shown at the top of the first page of the accompanying letter is incorrect, provide the correct information in the space provided below. (Do not complete if the information is correct).

Name: \_\_\_\_\_ Claim Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

PART G - CERTIFICATION

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 EEOICPA may be subject to criminal prosecution, from which a fine and/or imprisonment may result.

I understand that I must immediately report to DEEOIC any third party or state workers' compensation settlement I receive, any tort suit I file against a beryllium vendor or atomic weapons employer, any change in the status of a survivor, and any conviction for fraud committed against this program or any other federal or state workers' compensation law.

I certify that all the statements made in response to questions on this enclosure are true, complete and correct to the best of my knowledge and belief. I have placed "Not Applicable (N/A)" or "None" next to those questions that do not apply to me or my claim.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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