# Certification of Funeral Expenses

Print Reset

## U.S. Department of Labor

Office of Workers' Compensation Programs

The information provided on this form will be used to determine the amount of funeral expenses that are payable. Completion of the form is required to obtain payment for services performed (20 C.F.R. § 702.121.) The DOL makes no assurances of confidentiality to respondents. As a practical matter, the DOL would only disclose information collected under these requests in accordance with the provisions of the Freedom of Information Act, 5 U.S.C. § 552; the Privacy Act, 5 U.S.C. § 552a; and related regulations, 29 C.F.R. parts 70, 71.

OMB No. 1240-0040
Expires: XX-XX-XXXX

**For Office Use**

1. OWCP No.

2. Carrier's No.

3. Name of deceased

4. Funeral Director (Name, address, ZIP code)

| 5. **Services Performed** (itemize below and enter costs) | | |
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| Comments | **Total Bill** | $ | |
| | **Amount Paid** | $ | |
| (If additional space is required continue on reverse) | **Amount Due** | $ | |

6. I was informed that the above bill would be paid by — Enter name, address, and relationship to deceased.

7. This amount, $_____, of the bill was paid by — Enter name, address, and relationship to deceased.

**Certification**

**I certify that this concern performed the above services and that no further part of this bill has been paid.**

**It is therefore requested that payment, in accordance with the Longshore and Harbor Workers' Compensation Act or its extensions, be paid for the services indicated above.**

| 8. Signature and title (Type and sign) | Phone Number | 9. Date signed |
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**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 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 and maintaining the data needed, and completing and reviewing the collection of information. Use of this form is optional, however furnishing the information is required in order to obtain and/or retain benefits (20CFR 702.121). 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, 200 Constitution Avenue, N.W., Room C-4319, Washington, D.C. 20210, and reference the OMB Control Number.

**DO NOT SEND COMPLETED FORMS TO THIS OFFICE.**