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 because the claimant had claimed disability compensation prior to 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 and are in need of communication assistance, (such as alternate formats or sign language interpretation), accommodation(s) and/or modification(s), please contact OWCP.

Revised (05-16))

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 certify that the information provided above is true and accurate to the best of my knowledge and belief. 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 civil or administrative remedies as well as criminal prosecution

and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both. In addition, a state or federal criminal conviction for FECA fraud will result in termination of all current and future FECA benefits.

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.