U.S. DEPARTMENT OF LABOR

Office of Worker's Compensation Programs
Washington, DC 20210

OMB NO: 1240-0013
Expiration Date: xx-xx-xxxx

File Number:

Sender Address:

Phone:

Date:

Date of Injury:
Employee:

To (Recipient's Address):

Dear (Recipient's Name):

Additional information is needed in support of your claim for dependency compensation. Please supply answers to all questions on the attached questionnaire and complete the affidavit which follows.

Further consideration will be given to your claim on receipt of this evidence. This information is required to obtain a benefit (5 U.S.C. 8101 et seq.).

Sincerely,

Name of Signer:
Title

cc: (Names/Addresses receiving copy of letter)

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.

EVIDENCE REQUIRED IN SUPPORT OF A DEPENDENCY CLAIM

State the inclusive dates the deceased was employed during the 12 months immediately preceding death. Give the names and addresses of his or her employer(s) during that period, the rate of pay, and the total amount earned in each job.

State whether the deceased was living away from home at any time during the 12-month period before death. If so, give the inclusive dates. Forward any canceled checks, money order receipts, letters, or other evidence of the fact that the deceased contributed to your support during that time.

If you are now employed, give your Social Security account number, the name of your employer, your wages, and your occupation. If not now employed, explain why.

State whether your spouse survives. If he or she is employed, give their Social Security account number, employer's name, amount of wages, and occupation. If not employed, state why.

Furnish names and relationship to you of all persons who lived in the same household with you during the year preceding the death, and the monthly amount contributed by each toward support of the household.

State what support you have received from your surviving children since the death of the decedent. If they are now living with you and are not contributing to your support, state why.

List all real or personal property owned by you and your spouse, including money on deposit in the bank or invested, and the income from all property and investments.

Submit a copy of the record of birth of the deceased.

Submit an affidavit from at least two persons (preferably not related to you or to the decedent) who have actual knowledge of whether the decedent contributed to your support during the 12 months before death; whether you were dependent on these contributions for your livelihood; why this was true and how they (the affiants) know it to be true.

I certify that the information provided in the attached questionnaire 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

_____ _____

Signature Date

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 Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) 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 which the Office has will be used to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to retention, rehire, or other relevant matters. (4) Information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other healthcare providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection Act. (7) Disclosure of the claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/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, to verify earnings without further written authorization, and for other purposes required or authorized by law. (8) 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 or reduced level of benefits.

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 estimated to be 60 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the date 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.