

Claim for Continuance of Compensation
Under the Federal Employees'
Compensation Act

U.S. Department of Labor
Office of Workers' Compensation Programs



INSTRUCTION TO BENEFICIARIES

OMB No. 1240-0015
Expires: XX-XX-XXXX

1. It is important that you carefully complete the other side of this form and return it to the OWCP within 30 days. Your failure to do so will result in suspension of the compensation you are receiving.
2. Complete Section A by printing the full name of the deceased employee and the OFFICE OF WORKERS' COMPENSATION PROGRAMS file number.
3. Answer all questions in the section or sections that apply to you. If you are receiving compensation as the:
(A) SURVIVING SPOUSE - Complete Section B.
(B) SURVIVING SPOUSE RECEIVING COMPENSATION ON HER OR HIS ACCOUNT AND ON ACCOUNT OF A MINOR CHILD OR CHILDREN - Complete Sections B and C.
(C) GUARDIAN OR CUSTODIAN OF A MINOR CHILD OR GRANDCHILD OR A PERSON INCAPABLE OF SELF-SUPPORT - Complete Section C.
(D) PARENT, GRANDPARENT, OR A PERSON WHO IS PHYSICALLY INCAPABLE OF SELF-SUPPORT - Complete Section D.
4. Carefully read and comply with directions in Section E.
5. Complete and sign the certificate in Section F.
6. Please return the completed form, in an envelope, to the address shown below.

The information on this form will be used to determine your eligibility for continuing benefits. Your response to this information is required to retain your compensation benefits. Your benefits may be suspended if you fail to return this form within 30 days of the date of the request. (20 CFR 10.414)

**RETURN TO: U.S. DEPARTMENT OF LABOR, DFEC CENTRAL MAILROOM
P.O. BOX 8300
LONDON, KY 40742-8300**

OR

You can electronically upload documents into your case using the Employees' Compensation Operations and Management Portal (ECOMP). You can access ECOMP from any internet browser at: <https://www.ecomp.dol.gov/> . When you access the website, choose the "Upload Document" option. You will be asked to provide your case number, last name, date of birth and date of injury to upload a document. ECOMP will then provide you with a Tracking Number so that you can verify when OWCP has received your document. For more detailed information about this document submission feature, visit the ECOMP website and click "Help."

Privacy Act

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a) and the Computer Matching and Privacy Protection Act of 1988 (Public Law No. 100-503), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the Office receives and maintains personal information on claimants and their immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information collected by this form and other information collected in relation to your compensation claim may be verified through computer matches. (4) The information may be given to Federal, State, and local agencies for law enforcement and for other lawful purposes in accordance with routine uses published by the Department of Labor in the Federal Register. (5) Failure to furnish all requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits. (Disclosure of a social security number (SSN) is required by 42 U.S.C. 405 and 20 C.F.R. 105(a). Your SSN may be used to request information about you from employers and others who know you, but only as allowed by law or Presidential directive. The information collected by using your SSN may be used for studies, statistics, and computer matching to benefits and payment files.)

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB number.

Public Burden Statement

We estimate that it will take an average of 5 minutes per response to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.

Accommodation Statement

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodations and/or modifications, please contact OWCP.

IMPORTANT: READ CAREFULLY THE INSTRUCTIONS ON THE OTHER SIDE OF THIS FORM BEFORE ANSWERING THE QUESTIONS BELOW

I HEREBY APPLY FOR CONTINUANCE OF COMPENSATION BENEFITS AWARDED TO ME (OR TO THE CLAIMANT ON WHOSE BEHALF I AM ACTING) BY THE OFFICE OF WORKERS' COMPENSATION (OWCP) ON ACCOUNT OF THE DEATH OF:

A. Name of Deceased Employee	Employee's Federal Retirement Plan <input type="checkbox"/> CSRS <input type="checkbox"/> FERS <input type="checkbox"/> Other	OWCP File No.
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THIS BLOCK TO BE COMPLETED BY SURVIVING SPOUSE RECEIVING COMPENSATION

B. 1. Name	Social Security Number
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2. Have You Married since the Death of Above Named Employee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(If "Yes" complete 13)
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3. Do You Receive a Benefit, Pension or Allowance from any other Federal Agency such as the Veterans' Administration, Social Security Administration or the Office of Personnel Management on Account of the Death of this Employee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(If "Yes" complete 14)
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THIS BLOCK TO BE COMPLETED BY ANY PERSON RECEIVING COMPENSATION ON BEHALF OF CHILD GRANDCHILD, OR DEPENDENT INCAPABLE OF SELF-SUPPORT

C. 4. Name	Social Security Number
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5. Have any Dependents receiving compensation married, turned 18, or left school if over 18 since the Death of the Above Named Employee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(If "Yes" complete 13)
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6. Do Any Dependents You Claim Compensation for Receive a Benefit, Pension or Allowance from Any Other Federal Agency such as the Veterans' Administration, Social Security Administration, or the Office or Personnel Management on Account of the Death of this Employee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(If "Yes" complete 14)
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7. Give the Following Information for Each Person You Receive Compensation for or are Aware may be Receiving Compensation on Account of the Employee's Death:

NAME	SOCIAL SECURITY NUMBER	AGE	IS PERSON IN YOUR CUSTODY? (Yes or No)	NAME, ADDRESS, AND RELATIONSHIP OF PERSON(S) HAVING CUSTODY IF NOT IN YOUR CUSTODY

THIS BLOCK IS TO BE COMPLETED BY PARENT, GRANDPARENT, GUARDIAN OR DEPENDENT PHYSICALLY INCAPABLE OF SELF-SUPPORT

D. 8. Name	Social Security Number
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9. Have You Married since the Death of Above Named Employee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(If "Yes" complete 13)
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10. Do You Receive a Benefit, Pension or Allowance from any other Federal Agency such as the Veterans' Administration, Social Security Administration or the Office of Personnel Management on Account of the Death of this Employee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(If "Yes" complete 14)
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11. Are You Capable of Self-Support?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
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12. Have You Been Employed Since Filing Your Last Claim Form?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(If "Yes" complete 15)
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ADDITIONAL INFORMATION: THIS BLOCK TO BE COMPLETED ONLY WHEN AN ANSWER TO 2, 3, 5, 6, 9, 10 or 12 IS "YES."

E. 13. When and Where was the Marriage Performed and What was the Change in Name, If Any? HOW OLD WERE YOU AT THE TIME OF MARRIAGE?

14. What Agency is Paying the Benefits and For What Reason Are They Being Paid?

15. State the Name of Your Employer, Nature of Employment, Dates Employed, and Amount Earned.

BENEFICIARY'S CERTIFICATION - TO BE COMPLETED IN ALL INSTANCES

F. I CERTIFY THAT THE INFORMATION PROVIDED ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF AND THAT I WILL IMMEDIATELY NOTIFY THE OFFICE OF WORKERS' COMPENSATION PROGRAMS OF ANY CHANGES IN STATUS. 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 of Beneficiary (or guardian)	Date (month, day, year)
Address of Beneficiary (or guardian)	Telephone Where You Can Be Reached
Name of Witness if Beneficiary Signs by Mark (X)	Telephone Number of Witness
Signature of Witness	Date Witnessed