

Date  
Accepted Condition(s):

Case ID Number:

NAME  
STREET ADDRESS  
CITY, STATE ZIP

Dear :

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 verify that you are eligible to continue receiving medical or other benefits for your accepted condition(s) as shown above. Please answer all questions and return the enclosure within 30 days of the date of this letter to the following address:

U.S. Department of Labor OWCP/DEEOIC  
PO Box 47050  
San Antonio, TX 78265

You may also FAX the enclosure to us at: (insert FAX number).

Pub. L. 100-503 provides that the statements on the enclosure and other information in your claim file may be verified through computer matches. The Division of Energy Employees Occupational Illness Compensation (DEEOIC) may also request that you submit additional factual evidence to support your responses, if needed.

**READ ALL INSTRUCTIONS CAREFULLY BEFORE FILLING OUT THE ENCLOSURE. 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.

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**If you have a disability (a substantially limiting physical or mental impairment), please contact our office for information about the kinds of help available, such as**

**communication assistance (alternate formats or sign language interpretation),  
accommodations and modification.**

OMB Control No. 1240-0002  
Expiration Date: 03/31/2022  
2016

EE-12  
November

Your signature certifies that you have supplied all information requested by the enclosure. If you have any questions about completing the enclosure, call me at (111) 222-3333 or write to me at the address given above.

Sincerely,

Name  
Title  
Office

Enclosure: EN-12

**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 30.100 and 30.505). 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, 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-12. **Do not submit the completed form to this address.**

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Claimant:

### SECTION A - CURRENT CONTACT INFORMATION

If you have a different mailing address from the one shown at the top of the first page of the cover letter, provide your new information in the space provided below. Do not complete if the information is correct. Also, provide a current telephone number.

Address: \_\_\_\_\_  
City and State: \_\_\_\_\_  
Zip Code: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

### SECTION B - STATE WORKERS' COMPENSATION

1. Have you filed for and/or received any state workers' compensation for your accepted condition(s) since you were awarded EEOICPA benefits? Yes or No:

\_\_\_\_\_

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

Date of filing: \_\_\_\_\_  
State in which you filed: \_\_\_\_\_  
Name of employer, insurer or state that paid: \_\_\_\_\_  
Amount of monetary benefits received: \$ \_\_\_\_\_  
Type of benefits (disability, impairment, etc.): \_\_\_\_\_

List the same information for any other state workers' compensation received after being awarded EEOICPA benefits on an extra sheet.

### PART C - 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, provide:

Date of conviction or guilty plea: \_\_\_\_\_  
Jurisdiction where fraud charges were brought: \_\_\_\_\_

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### SECTION D - TORT AWARDS OR SETTLEMENTS

1. Since you were awarded EEOICPA benefits, have you received any settlement or award from a claim or tort suit (other than a claim for workers' compensation) against a third party in connection with an exposure to a toxic substance for which you received EEOICPA benefits? Yes or No: \_\_\_\_\_

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

Date of award or settlement: \_\_\_\_\_

Party or parties involved: \_\_\_\_\_

Type of suit or settlement: \_\_\_\_\_

Amount of award or settlement: \$ \_\_\_\_\_

List any other tort awards or settlements below or on an extra sheet.

### SECTION E - 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 the Energy Employees Occupational Illness Compensation Program Act 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 state workers' compensation benefits or tort awards/settlements I receive.

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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