

Date:

Case ID Number:

Response requested

Name
Street Address
City, State ZIP

- First Request
 Second Request
 Final Request

Dear :

This letter is in regard to your claim under Part E of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). Your claim has been accepted for the following illness(es): . As such, you may be eligible for a monetary award for wage-loss caused by the accepted illness(es).

Wage-Loss: Wage-loss benefits: **(1)** are awarded if the accepted illness(es) caused or contributed to an employee's loss of earnings; and **(2) are payable only** for the calendar years of wage-loss experienced before an employee's normal Social Security retirement age. A person's normal retirement age is based on the year when he/she was born and is usually 65 years of age, but can be as high as 67 years of age (see the enclosed Social Security Retirement Age Table). Wage-loss benefits are payable only through the calendar year when normal retirement age is reached.

Based on the above criteria, if you believe you (either as the employee or as the employee's survivor) may qualify and wish to file for wage-loss benefits, please complete the enclosed Form EN-11B (Wage-Loss Benefits Response Form) and be sure to provide the following information:

- Check "**YES**" to indicate that you are seeking wage-loss benefits.
- Enter the month and year {your or the employee's} initial wage-loss began due to the accepted illness(es).
- Enter the months and years {you or the employee} last experienced wage-loss as a result of the accepted illness(es).

In addition, earnings and medical documentation must be submitted to support the period of wage-loss being claimed as discussed below.

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.

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Earnings: For proof of wage-loss, we need the records of earnings for the 12 quarters (36 months) prior to the quarter when {you or the employee} first experienced wage-loss. We also need records of earnings up to the present or when the wage-loss ceased (or through the year of normal retirement age). To assist us in this effort, you may submit any legible copies of trustworthy earnings records for this period of time. This includes, but is not limited to:

• Social Security earnings statements	• Social Security disability records
• Tax Returns	• Pay Stubs
• Union Records	• Pension Records

To help you in this regard, we will also attempt to obtain earnings records from the Social Security Administration.

Medical: In addition, you must provide medical evidence establishing a causal relationship between the accepted illness(es) and the wage-loss. Examples of this may include:

- Medical reports or doctor’s notes showing an inability to work as a result of one of the above accepted illnesses;
- Return to work slips signed by a doctor;
- A doctor’s report explaining the causal relationship between the accepted illness(es) and the period(s) of wage-loss. This may include a medically-required reduction in work-hours or a change to a lower-paying job.

If you elect not to pursue a wage-loss claim at this time, please mark “**NO**” on Form EN-11B and we will not further develop the issue. Also, if this letter is identified above as a “Final Request” and we do not hear from you, we will also not develop this issue further. However, you retain the right to pursue a wage-loss claim in the future simply by notifying us in writing and sending it to the address at the bottom of the enclosed EN-11B.

We would appreciate receiving your written response within 30 days. If you have any questions regarding this letter or wage-loss benefits in general, or you need additional

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time to submit the requested information, please do not hesitate to contact me. You may call me at (xxx) xxx-xxxx.

Sincerely,

Name
Title
Office

Enclosure: Pamphlet, "*Wage-Loss Benefits*"
Social Security Retirement Age Table
EN-11B

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 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. (4) 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 30 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 30.505). Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them 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-11B. **Do not submit the completed form to this address.**

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Employee Name:

Wage-Loss Benefits Response Form

YES, I wish to pursue a claim for wage-loss benefits for my accepted illness(es).

- The initial wage-loss due to my illness(es) began:
_____/_____(Month/Year)
- I am claiming wage-loss due to my accepted illness(es) for the following period:
From: ____/____(Month/Year) To: ____/____(Month/Year)

NO, I am not pursuing wage-loss benefits at this time. I understand that I can file for wage-loss benefits in the future by submitting a signed statement to that effect to the district office.

Signature (Required)

Signature

Date

Mail form to: DOL DEEOIC Central Mail Room Correspondence
P.O. Box 8306
London, KY 40742-8306

Or you may FAX it to: DO FAX Number

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