Date

Employee:
Case ID Number:

NAME
STREET ADDRESS
CITY, STATE ZIP

Dear :

This letter is in regard to your claim for compensation under the Energy Employees Occupational Illness Compensation Program Act of 2000, as amended.

We are currently in the process of determining your eligibility for benefits. Our next step in this process will be to calculate the probability of causation for the diagnosed cancer(s). The calculation of probability is based on many factors, such as the length of exposure and proximity to radiological sources, the type of safety protection worn, the type of cancer diagnosed, etc.

Another factor that must be included in the calculation for skin cancer, or a secondary cancer for which skin cancer is a likely primary cancer, is the race or ethnic identification of the employee. This information must be entered into the computer program that we are required to use to determine the probability of causation.

Attached to this letter is an enclosure that must be completed in order for the claim to proceed. Please fill out the enclosure fully and return it by either mail or FAX to the office listed at the bottom. We ask that the enclosure be returned within thirty (30) days so as to avoid any delay in the claims adjudication process. Without this completed enclosure, a determination concerning your entitlement to monetary benefits cannot be issued.

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.

If you have any questions or concerns, please contact the District Office at .

Sincerely,

Name
Title
Office

Enclosure: EN-9

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 5 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 30.213). 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-9. **Do not submit the completed form to this address.**

Employee: Case ID Number:

For claims involving radiogenic skin cancer, racial or ethnic identification is incorporated into the calculation of probability of causation. It is a required element of the program. In order to proceed with a determination of causation, please mark the box that best matches the racial or ethnic identification of the employee named above:

- ☐ American Indian or Alaska Native
- ☐ Asian, or Native Hawaiian or Other Pacific Islander
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ White or Caucasian

Any person who knowingly makes any false statement, concealment of fact, misrepresentation, or commits any other act of fraud to obtain compensation as provided under EEOICPA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both. I certify that the information provided is accurate and true.

Print Name: _____

Signature: _____

Date: _____

Return Form EN-9 to: U.S. Department of Labor OWCP/DEEOIC
P.O. Box 8306
London, KY 40742-8306

FAX: