File Number: «CaseNumber»
«FORM»-«CAT»-«SUBJ»

OMB No: 1240-0013
Expiration Date: 07/31/2023

U.S. DEPARTMENT OF LABOR

«SenderAddress»
Phone: «SenderPhone»

Date of Injury: «DtInjury»
Employee: «ClaimantFullName»

«ToAddress»

Dear «Salutation»:

Compensation may continue to be paid on behalf of an unmarried child age 18 or older who is either a full-time student or incapable of self-support. We need additional information to determine whether «usr_CHILD_NAME» has continuing eligibility for compensation beyond the eighteenth birthday.

«usr_OPTIONAL_PARAGRAPHS_1»

The law prohibits the acceptance of compensation when a dependent is no longer entitled to it. If the dependent is «usr_OPTIONAL_PARAGRAPHS_NNL_2»

Any compensation payment you receive after such a change in status of the dependent must be returned to this office for cancellation. It will be replaced with a payment in the correct amount.

Sincerely,

Federal Employees Program

Enclosures

«CCAddresses»

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.

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 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. (5) 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.

We are authorized to request a taxpayer identification number (TIN) or Social Security Number (SSN) under the Debt Collection Improvement Act of 1996, Title 31 U.S.C. amended section 7701(c) (1), which mandates us to require regulated entities and persons who are doing business with a Federal agency to furnish a TIN or SSN. The 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.

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 is estimated to average to vary from 15 to 45 minutes per response with an average of 30 minutes per response, including the time for reviewing data needed, and completing and reviewing the 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.

PART A- TO BE COMPLETED BY CLAIMANT

1. Name of dependent for whom you claim compensation: _____

2. Date of dependent's birth: _____

3. Dependent's Social Security Number: _____

4. Has the dependent completed four years of education beyond high school? ____

5. Has the dependent married? ____ If so, give the date of marriage._____

6. Is the dependent now attending school on a full-time basis? ____
If so, on what date did attendance at this school begin? _____

7. Have you applied for educational benefits for this dependent from the Department of Veterans Affairs (VA)? ____
If so, have you received educational benefits from the VA? ____ Date benefits began: _____

I certify that the information given by me on this questionnaire is true, correct, and complete to the best of my knowledge. Any information left blank on this form has been done intentionally and indicates I had no information to provide for that question. I understand that any false statement, misrepresentation, or concealment of fact, in respect to this claim, may be grounds for forfeiture of compensation benefits and could subject me to civil liability or, if fraudulent, may result in criminal prosecution.

Signed_____Date_____

Address_____
(Street) (City) (State) (Zip)

PART B- TO BE COMPLETED BY SCHOOL OFFICIAL
Please refer to the accompanying Part A.

1. Is «usr_CHILD_NAME» currently enrolled in your institution fulltime?

2. Name and address of educational institution:

3. What are the beginning and ending dates of the present school year?

4. When should this student expect to complete the present course of study?

5. Is your school an accredited or licensed institution?

I have reviewed Part A and I certify that the information given by me on this questionnaire is true, correct, and complete to the best of my knowledge.

Signed_____

Title_____

Date_____

Return Parts A and B together to the following address:

U.S. Department of Labor
OWCP/DFEC
P.O. Box 8311
London, KY 40742-8311