File Number:
CA-1032-FO-CA1032
OMB No: 1240-0016
Expiration Date: 11-30-2023

U.S. DEPARTMENT OF LABOR

DFELHWC-FECA, PO Box 8311
LONDON, KY 40742-8311
Phone: (202) 513-6860

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DATE

Date of Injury: XX/XX/XXXX
Employee: CLAIMANT NAME

CLAIMANT ADDRESS

Dear: CLAIMANT

The information requested in this letter is required in connection with your benefits under the Federal Employees' Compensation Act (FECA), 5 U.S.C. 8101 et seq. This information will be used to decide whether you are entitled to continue receiving these benefits, or whether your benefits should be adjusted. Accordingly, you **must** report to OWCP any improvement in your medical condition, any employment, any change in the status of claimed dependents, any third-party settlement, and any income or change in income from Federally assisted disability or benefit programs.

You must completely answer all questions and return this statement within 30 days of the date of this letter. Otherwise, your benefits will be suspended in accordance with 20 CFR 10.528. Public Law 100-503 provides that the statements on this form and other information in your claim file may be verified through computer matches.

READ ALL INSTRUCTIONS CAREFULLY BEFORE FILLING OUT YOUR STATEMENT. 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.

WARNING

A FALSE OR EVASIVE ANSWER TO ANY QUESTION, OR THE OMISSION OF AN ANSWER, MAY BE GROUNDS FOR FORFEITING YOUR COMPENSATION BENEFITS AND SUBJECT YOU TO CIVIL LIABILITY. A FRAUDULENT ANSWER MAY ALSO RESULT IN CRIMINAL PROSECUTION OR CIVIL ACTION FOR FALSE CLAIMS. ALL STATEMENTS ARE SUBJECT TO INVESTIGATION FOR VERIFICATION.

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.

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This statement covers the 15 months prior to the date you complete and sign the form. Your signature at the end of the statement certifies that you have supplied all information requested for that period of time.

Sincerely,

Federal Employees Program

Enclosure(s): EN1032 (7 pages)

EMPLOYING AGENCY ADDRESS

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PUBLIC BURDEN STATEMENT

The OMB control number for this collection is 1240-0016 and expires on 11/30/2023.

According to the Paperwork Reduction Act of 1995, no person is required to respond to a collection of information unless such collection displays a valid OMB control number.

Collection of this information is authorized by (20 C.F.R. 10. 528). The obligation to respond to this collection is mandatory/required to obtain or retain benefit. We estimate it takes about 20 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing the collection of information.

Please send comments regarding the burden estimate or any other aspect of this collection of information to the U.S. Department of Labor, Office of Workers' Compensation Programs, 200 Constitution Avenue, NW, Room S-3229, Washington, DC 20210, or email suggs.anjanette@dol.gov, and reference OMB control number 1240-0016.

Note: Please do not return the completed Request for Information of Earnings, Dual Benefits, Dependents, and Third Party Settlements to this address.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

PRIVACY ACT STATEMENT

The Privacy Act of 1974 as amended, (5 U.S.C. 552a), and the Federal Employees' Compensation Act, as amended and extended (5 U.S.C 8101, et. seq) authorizes collection of this information. The information will be used to determine continuing entitlement to benefits. Furnishing the requested information is required for a claimant to obtain or retain a benefit. Failure to provide the information may result in the delay of a claim or payment of benefits, or may result in an unfavorable in a delay of a claim or payment of benefits, or result in an unfavorable decision or reduced levels of benefits. Additional disclosures of this information may be to: (1) to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (2) 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. (3) to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (4) to physicians and other healthcare providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (5) 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.

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PART A--EMPLOYMENT

Read this section completely before answering the questions below and on the next page. **Report ALL employment for which you received a salary, wages, income, sales commissions, piecework, or payment of any kind.** Such employment includes service with the military forces of the United States, including the National Guard, Reserve component, or other affiliates. Please note that you must report any employment held at the time of injury if you have worked at that employment during any period covered by this form.

Report ALL self-employment or involvement in business enterprises. These include but are not limited to: farming; sales work; operating a business, including a store or a restaurant; any online work/business; and providing services in exchange for money, goods, or other services. The kinds of services which you must report include such activities as carpentry, mechanical work, painting, contracting, child care, odd jobs, etc. Report activities such as keeping books and records, or managing and/or overseeing a business of any kind, including a family business. Even if your activities were part-time or intermittent, you must report them.

Report as your "rate of pay" what you were paid. Include the value of such things as housing, meals, clothing, and reimbursed expenses, if they were received as part of your employment.

Report ANY work or ownership interest in any business enterprise, even if the business lost money or if profits or income were reinvested or paid to others. If you performed any duties in any business enterprise for which you were not paid, you must show as “rate of pay” what it would have cost the employer or organization to hire someone to perform the work or duties you did, even if your work was for yourself or a family member or relative. You need not list ownership or passive investment in any publicly traded businesses. You need not list stocks or bank accounts.

If you have questions about whether something is material or relevant and should be included, please list that information. Under 5 U.S.C. 8106 (b), an employee who fails to make a report when required or knowingly omits or understates earnings for the period covered by the form forfeits the right to compensation for the period covered by this form.

CRIMINAL, CIVIL AND ADMINISTRATIVE PENALTIES MAY BE APPLIED FOR FAILURE TO REPORT ALL WORK ACTIVITIES THOROUGHLY AND COMPLETELY

1. **Did you work for any employer during the past 15 months?**

   a. Yes or No: _____
   b. If yes, state for each employer:
   Dates of employment:

_____

   Description of work done:

_____

   Rate of pay: $_____/hr/wk/mo Actual earnings:
$_____

   Name/address of employer:

_____

2. **Were you self-employed or involved in any business enterprise in the past 15 months?**

a. Yes or No: _____

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PART A—EMPLOYMENT (Continued)

b. If yes, state:
Dates of self-employment or involvement in business enterprise: _____
_____
Description of work or business involvement: _____
_____

Rate of pay: $_____/hr/wk/mo Actual earnings: $_____
Name/Address of place of employment or business:
_____
_____

3. **If you answered "No" to both questions 1 and 2,** state whether you were unemployed for all periods during the past 15 months: Yes or No: _____
If no, show dates of employment: _____

PART B--VOLUNTEER WORK

During the past 15 months, did you perform any volunteer work including volunteer work for which ANY FORM of monetary or in-kind compensation was received? Yes or No: _____ If yes, state the kind of work you did and include a description of that work:

_____

_____
What were the beginning and ending dates of the volunteer work?

_____
How often did you perform this work (hours per week, weeks per month, etc.)?

_____

PART C--DEPENDENTS

A claimant who has no eligible dependents is paid compensation at 66 2/3% of the applicable pay rate. A claimant who has one or more eligible dependents is paid compensation at 75% of the applicable pay rate. You must answer the questions below to ensure your compensation is paid at the correct rate.

You may claim augmented compensation for a dependent if you have one or more of the following: (a) a spouse (including a same sex spouse) who lives with you; (b) an unmarried child, including an adopted child or stepchild, who lives with you and is under 18 years of age; (c) an unmarried child who is 18 or over, but who cannot support himself or herself because of mental or physical disability; (d) an unmarried child under 23 years of age who is a full-time student and has not completed four years of school beyond the high school level; (e) a parent who totally depends upon you for support.

You may also claim compensation for a spouse (including a same sex spouse) or dependent who does not live with you if a Court has ordered you to pay support to that person. Finally, you may

PART C—DEPENDENTS (Continued)

claim compensation for (a) a spouse, (b) an unmarried child under 18, or (c) an unmarried child between 18 and 23 who is a full-time student even if that person does not live with you if you make regular payments for his or her support. YOU MAY NOT CLAIM OR RECEIVE AUGMENTED COMPENSATION FOR AN EX-SPOUSE EVEN IF YOU HAVE BEEN ORDERED TO PROVIDE SUPPORT IN THE FORM OF ALIMONY.

1. Are you married? Yes or No: _____
   If yes, does your spouse live with you? Yes or No: _____
   If no, please provide the date your spouse no longer resided with you: _____
   If your spouse does not live with you, do you make regular payments for his or her support? Yes or No: _____ If yes, describe the support provided:_____
   _____
   _____

2. Do you claim compensation on account of a child? Yes or No: _____
   If yes, complete the following for each child:
   Full Name:_____
   _____
   Date of Birth (and student status if over 18 and under 23): _____
   _____

   Do you claim compensation based on other non-child dependents? Yes or No: _____
   If yes, complete the following for each non-child dependent:
   Relationship to You: _____
   Resides with you? Yes or No: _____
   If this dependent does not live with you, do you make regular payments for his or her support? Yes or No: _____ If yes, describe the support provided:_____
   _____
   _____

   List any other dependents with all information outlined above, including the circumstances of a fully dependent parent, on an extra sheet. Remember to include your name and claim number at the top and to sign and date each extra sheet.

3. You are required to report any changes in dependents as soon as those changes occur. If you are receiving compensation for a dependent and are no longer entitled to receive that compensation, state:
   Date the person stopped being a dependent _____
   Reason the person stopped being a dependent _____
   _____

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PART D--OTHER FEDERAL BENEFITS OR PAYMENTS

Report any benefits you receive from the Office of Personnel Management (OPM), the Social Security Administration (SSA), the Foreign Service, or any other Federal disability or retirement system . DO NOT report benefits received under the FECA.

1. **OPM Benefits**. Report any disability or retirement benefits you receive from the OPM.

   a. Have you been assigned a CSA number? Yes or No: _____
   If yes, write it here: _____

   b. During the past 15 months, have you received a:
   Regular retirement check from OPM? Yes or No: _____
   Disability retirement check from OPM? Yes or No: _____

   Note: When OPM receives your retirement application, they assign a CSA number. It's a seven digit number and will be included on all correspondences from OPM.

2. **Social Security Administration (SSA) Benefits**.

   a. Are you receiving any benefits from SSA? Yes or No: _____

   b. If yes, please select benefit type: _____ Retirement Benefits
   _____ Disability Benefits

   c. If you receive retirement benefits from SSA attributable even in part to your Federal service, your FECA benefits are subject to an offset.

   If you are in receipt of retirement benefits from SSA, please complete the following:
   _____ Your Age
   _____ Your Federal Retirement Coverage (CSRS, FERS, CSRS Offset, Other). If other, explain._____
   _____ Your Monthly Benefit if your retirement is not CSRS

   Note: If you receive SSA disability benefits, those SSA disability benefits may be reduced by SSA due to your receipt of FECA benefits.

3. **VA Benefits.** Report any Veterans Administration (VA) disability award resulting from the injury for which you receive benefits under the FECA.

   a. Do you receive benefits from the VA on account of service in the Armed Forces of the United States? Yes or No: _____

   b. If yes, state your file number: _____
   Also state the kind of disability for which the award was made: _____
   _____

   c. Has the percentage of your VA award increased since the injury for which you are receiving benefits under the FECA?

Yes or No: _____ If yes, give date of increase: _____

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PART D--OTHER FEDERAL BENEFITS OR PAYMENTS (Continued)

4. **Other Benefits.** Report any Federal Black Lung benefits or any other benefits paid by the Federal government **not** including benefits under the FECA. If you have received any state benefits such as state workers compensation benefits or Unemployment Compensation during the period covered by this form, please also list such benefits below, as such benefits may be offset or reduced for FECA benefits received.

   a. Have you received any other Federally funded or assisted benefits or other state benefits such as described above? Yes or No: _____

   b. If yes, provide the following information for each such benefit or payment:

   Type of Claim/Award/Benefit: _____
   Agency and Address: _____
   _____
   Claim or File No.: _____
   Amount/Value Received _____ Weekly or Monthly? _____
   Dates for which benefits received: _____
   Do you still receive these benefits regularly? Yes or No: _____

PART E—THIRD-PARTY SETTLEMENT

1. In the past 15 months, did you or an attorney acting on your behalf file a suit or any type of claim (insurance, legal or otherwise) against a third party in connection with an injury or illness for which you receive compensation? Yes or No: _____

2. If yes, state:
   Type of suit or claim: _____
   Name, address, and phone number of attorney, if applicable: _____
   _____
   _____

3. In the past 15 months, did you receive any settlement or award from a claim or suit against a third party in connection with an injury or illness for which you receive compensation? This includes any product liability or medical malpractice settlement/award you have received that relates to treatment for your accepted injury or illness. Yes or No: _____

4. If yes, state:
   Date of judgment or settlement: _____
   Party or parties involved: _____
   Type of suit or settlement: _____
   Amount of judgment or settlement: _____
   Legal fees and Court costs: _____

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PART E—THIRD-PARTY SETTLEMENT (Continued)

Name, address, and phone number of attorney, if applicable: _____
_____
_____

PART F--FRAUD OFFENSES

1. Have you been convicted of any fraud – related offense in connection with the application for or receipt of workers' compensation benefits? Yes or No:_____
   If yes, state date of conviction: _____

2. Have you been incarcerated for any period during the past 15 months for any felony offense that resulted in a conviction under state or federal law?
   Yes or No:_____ Place of incarceration and dates:_____

PART G--CORRECTIONS

If the name, address, file number, or date of injury shown at the top of the first page of this letter is incorrect, provide the correct information in the space provided below. (Do not complete if the information is correct).

Name: _____ File Number: _____
Address: _____ Date of Injury: _____
_____

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PART H—CERTIFICATION

I know that anyone who fraudulently conceals or fails to report income or other information which 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 Federal Employees' Compensation Act may be subject to criminal prosecution, from which a fine or imprisonment, or both, may result. I know that fraudulently concealing or failing to report income or other information in claiming payment or benefit under FECA may result in the forfeiture of compensation for the period covered by this form and may also result in a civil action against me for damages under the False Claims Act or other applicable laws.

I understand that I must immediately report to OWCP any employment or employment activity, any change in the status of claimed dependents, any third party settlement, and any monies or income or change in monies or income from Federally assisted disability or benefit programs.

I certify that all the statements made in response to the questions on this form 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

_____ _____

Street Address Telephone

_____

City, State and Zip

ATTENTION:
You can mail your signed and dated form to the address at the top of this letter ***OR*** you may electronically submit the signed and dated form for immediate receipt. Electronically uploaded documents will be directly entered into your FECA 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."

You may use this electronic document submission option for ***any written communication*** with OWCP concerning your case. Your physician may also use this feature to submit medical reports for your case.

If you would like to complete an anonymous customer service survey, please visit our website at:

http://www.dol.gov/owcp/

When you access our website, look for this link: