

**Claim for Consequential Illness Benefits  
Under the Energy Employees Occupational  
Illness Compensation Program Act**

**U.S. Department of Labor**  
Office of Workers' Compensation  
Programs  
Division of Energy Employees  
Occupational  
Illness Compensation



A consequential illness is a separately diagnosed medical condition that a physician concludes occurred or worsened because of an illness that has already been accepted as work-related under the Energy Employees Occupational Illness Compensation Program Act. **Do not use this form to claim an illness that resulted from an occupational toxic substance exposure.** Please read the instructions on page 2 before filling out this form. Provide all information requested, and sign and date the bottom of page 1.

OMB Control No.  
XXXX-XXXX  
  
Expiration Date:  
XX/XX/20XX

**Employee Information** (Please Print Clearly)

<b>1. Name</b> (Last, First, Middle Initial)		<b>2. Case ID Number</b>	
<b>3. Address</b> (Street, Apt. #, P.O. Box)  (City, State, ZIP Code)		<b>4. Telephone Number(s)</b> a. Home: (     )     - b. Other: (     )     -	

**5. Identify the Consequential Illness(es) Being Claimed as Related to an Accepted**

Specific medical diagnosis only. Do <u>not</u> list symptoms (e.g., pains, aches, cough).	6. Date of Diagnosis		
	Month	Day	Year
a.			
b.			
c.			
d.			
e.			

**Awards and Other Information**

7. Have you filed a lawsuit based on exposure to radiation, beryllium, asbestos or any other toxic	<input type="checkbox"/> YES <input type="checkbox"/> NO
8. Have you filed any state workers' compensation claims in connection with any condition(s) you claim	<input type="checkbox"/> YES <input type="checkbox"/> NO
9. Have you or another person received a settlement or other award in connection with a lawsuit or state workers' compensation claim described in Questions 7 or 8?	<input type="checkbox"/> YES <input type="checkbox"/> NO
10. Have you either pled guilty to, or been convicted of, any charges connected with an application for, or receipt of, federal or state workers' compensation?	<input type="checkbox"/> YES <input type="checkbox"/> NO

**Claimant Declaration**

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or 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. Any change to the information provided on this form once it is submitted must be reported immediately to the district office responsible for the administration of the claim. I hereby make a claim for benefits under EEOICPA and affirm that the information I have provided on this form is true. I authorize any physician or hospital (or any other person, institution, corporation, or government agency, including the Social Security Administration) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs.

<b>Resource Center Date Stamp</b>

\_\_\_\_\_ Claimant Signature

\_\_\_\_\_ Date

## Instructions for Completing Form EE-1A

Consequential Illness(es) Being Claimed - A consequential illness is any illness, injury, impairment, or disease that is medically linked by a physician to be caused by, contributed to, or aggravated by an accepted illness under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). A condition resulting from medical treatment of an accepted illness can also be filed as a consequential illness.

**Complete this form when claiming consequential illness coverage under Part B and/or Part E of the EEOICPA. A physician must conclude that the claimed consequential illness occurred or worsened due to a medical condition accepted as work related under Part B and/or Part E. If filing for a new illness resulting from an occupational toxic substance exposure, complete Form EE-1 (Worker's Claim for Benefits under the EEOICPA) or form EE-2 (Survivor's Claim for Benefits under EEOICPA)**

This form may be completed by a covered employee, a qualifying survivor of a covered employee, or someone with the legal capacity to sign on behalf of another person (i.e., attorney-in-fact). The claimant making the claim must complete all items and sign the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. If the requested information is not submitted, you should explain the reason(s) for the delay and indicate when the information will be forthcoming. Submit the completed claim form and all other pertinent documentation to the following address:

U.S. Department of Labor  
OWCP/DDEOIC  
P.O. Box 8306  
London, KY 40742-8306

Alternatively, you can complete this form online via the Energy Document Portal (EDP) at <https://eclaimant.dol.gov>. If you choose to complete your form online via the EDP, mailing the form is not necessary.

**Item 2** - List Case ID Number associated with the claim for an illness previously accepted under Part B and/or Part E of the EEOICPA.

**Item 5** - Identify the specific physician-diagnosed illness(es) that you claim is related to an EEOICPA accepted illness. Do not list symptoms (e.g., aches, pains, cough, wheezing, breathing problems). If you require additional space, complete a separate Form EE-1A. \_\_

**Item 6** - List the date a physician first diagnosed the consequential illness(es) for each illness claimed.

### Awards and Other Information

**Item 7** - Mark the appropriate box indicating whether you have filed a civil lawsuit based on exposure to any toxic substance. If you mark the box for YES, provide copies of all pertinent court documentation.

**Item 8** - Mark the appropriate box indicating whether you have filed any state workers' compensation claims in connection with any illness(es) you claim in Item 5. If you mark the box for YES, provide copies of all pertinent state workers' compensation documentation.

**Item 9** - Mark the appropriate box indicating whether you or another person received a settlement or other type of award from a lawsuit or a state workers' compensation claim described in Items 7 or 8. If you mark the box for YES, provide copies of all pertinent documentation.

**Item 10** - Mark the appropriate box indicating whether or not you have ever pled guilty to or been convicted on any charges connected to an application for or receipt of federal or state workers' compensation.

### 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) 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 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering the data needed, and completing and reviewing the collection of information. You are required to respond to this collection to obtain EEOICPA benefits (20 CFR § 30.505(a)). 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. 1240-0NEW and Form EE-1A. **Do not submit the completed form to this address.**