U.S. Department of Homeland Security
Transportation Security Administration
6595 Springfield Center Drive
Springfield, Virginia 20598

TODAY.DATE

CLAIMANT.COMPANY
CLAIMANT.TITLE CLAIMANT.FIRST_NAME CLAIMANT.LAST_NAME
CLAIMANT.ADDRESS1
CLAIMANT.ADDRESS2
CLAIMANT.CITY, CLAIMANT.STATE CLAIMANT.ZIP
CLAIMANT.COUNTRY

Re: TSA Control Number: **CLAIM.CLAIM_NUMBER**

Dear CLAIMANT.TITLE CLAIMANT.FIRST_NAME CLAIMANT.LAST_NAME:

We have reevaluated your claim against the United States under the Federal Tort Claims Act. Based on this review, and applicable law, the Transportation Security Administration (TSA) offers to settle your claim by paying you $CLAIM.CLOSE_AMOUNT. This final offer is one half of the amount you claimed or substantiated (less any depreciation) because we concluded that it was not possible to determine whether TSA or your air carrier was responsible for your loss.

To accept or reject this final offer, please complete the enclosed form and return it to TSA via:

Mail: Claims, Outreach, and Debt Branch – TSA-9
ATTN: **CLAIM.CLAIM_NUMBER – SETTLEMENT**
Transportation Security Administration
6595 Springfield Center Drive
Springfield, Virginia 20598-6009

Fax: For faster service, please fax to: (703) 603-4092

Acceptance of this payment is final and conclusive, and constitutes a complete release of any claim against the United States and against any TSA employee whose alleged negligent or wrongful act or omission gave rise to this claim, by reason of the same subject matter. If we do not receive your response within 90 days, we will presume that you have rejected the offer and deny your claim.

Should you have any questions, you may reach the Claims, Outreach, and Debt Branch at (571) 227-1300 or by e-mail at TSAClaimsOffice@tsa.dhs.gov.

Enclosure

ATTACHMENT TO FTCA CLAIM SETTLEMENT LETTER ***Reevaluation***
CLAIM.CLAIM_NUMBER - CLAIMANT.LAST_NAME - $CLAIM.CLOSE_AMOUNT

You must **ACCEPT** or **REJECT** this final settlement offer, **SIGN** this document, and **RETURN** it to TSA.

☐ I **ACCEPT** this offer.

Payee Social Security Number or other taxpayer identification number: _____

Payee Name or Company: _____

Address (P.O. Boxes are not accepted): _____

City: _____State: _____ Zip: _____ Country: _____

NOTICE: If you choose this option, you are accepting the offered payment in full satisfaction and release of all claims relating to the incident from which your claim arose. If your claim is governed by California law, you waive the protections of Calif. Civ. Code § 1542. I and my guardians, heirs, executors, administrators, and assigns ("**I**") agree to and do accept this settlement in full settlement and satisfaction and release of any and all claims, demands, rights, and causes of action of any kind, whether known or unknown, including without limitation any claims for fees, costs, expenses, survival, or wrongful death, arising from any and all known or unknown, foreseen or unforeseen bodily injuries, personal injuries, death, or damage to property, which **I** may have or hereafter acquire against the United States of America, its agents, servants, or employees, on account of the subject matter of **My** administrative claim, or that relate or pertain to or arise from, directly or indirectly, the subject matter of **My** administrative claim. **I** further agree to reimburse, indemnify, and hold harmless the United States of America, its agents, servants, and employees, from and against any and all claims, demands, rights, and causes of action of any kind, whether known or unknown, including without limitation claims for subrogation, indemnity, contribution, or lien of any kind, or for fees, costs, expenses, survival or wrongful death that relate or pertain to or arise from, directly or indirectly, any act or omission that relates to the subject matter of **My** administrative claim.

Payment Method:

- ☐ I request a check mailed to the address above. (You will receive a check from the U.S. Treasury)
- ☐ I request payment by electronic funds transfer into the following account: (Deposit will be from the U.S. Treasury. Deposit code will show as USCG Treas or CGVA.) **Option for U.S. bank payments only - any errors or omissions in the banking information below may result in your payment being mailed to the above address. Bank account must be in the claimant's (or guardian) name.**

Payee Account Name:	U.S. Bank Name:
U.S. Routing Number/ABA Bank # (9 digits):	U.S. Bank Address:
Payee Account #:	
Check One: ☐ Checking Account ☐ Savings Account	

☐ I **REJECT** this final offer. I understand that by checking this option, my administrative claim will be denied.

I acknowledge that I am acting in my capacity as the claimant; as the claimant's duly authorized agent; or as the claimant's legal representative.

Authorized Signature: _____ Date: _____

PRIVACY ACT STATEMENT AND PAPERWORK REDUCTION ACT STATEMENT

AUTHORITY: 31 U.S.C. 3325(d); 31 U.S.C. 3332. **PRINCIPAL PURPOSE(S):** This information will be used to remit payment of your claim. **ROUTINE USE(S):** The information you provide, including your social security number, will be disclosed to the U.S. Treasury Department to determine whether you have any outstanding debts to the government that should be paid from your settlement and may also be disclosed to other Federal agencies in order to process your claim, or for other routine uses listed in the applicable system of records notices. **DISCLOSURE:** Voluntary; failure to furnish the requested information may result in a delay or denial of payment on your claim. Failure to provide your SSN or taxpayer identification number may result in a delay of payment of your claim.

Paperwork Reduction Act Statement of Public Burden: TSA is collecting this information because a determination has been made regarding your tort claim against the agency that payment is warranted; therefore TSA needs certain information to facilitate payment. The public burden for this collection of information is estimated to be approximately 30 minutes. This is a voluntary collection of information; however, failure to provide this information may delay or hinder the processing of your claim payment. An agency may not conduct or sponsor, and persons are not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number assigned to this collection is 1652-0039, which expires 03/31/2025.