Impairment/Wage-Loss Benefits Claim 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

Note: Read the instructions on page 2 before filling out this form. Provide all information requested, and sign and date the bottom of page 1. Do not write in the shaded area.

OMB Control No. 1240-0002

Expiration Date: XX/XX20XX

Employee Information (Please Print Clearly)

1. Name (Last, First, Middle Initial)

2. Case ID Number

3. Address (Street, Apt. #, P.O. Box)

(City, State, ZIP Code)

4. Telephone Number(s)

a. Home: ( ) -

b. Other: ( ) -

5. Options and Selection for Impairment or Wage-Loss Claim(s)

Option A - I have not received a prior impairment and/or wage-loss award because of my accepted condition(s). This claim is for an **initial** award for whole-person impairment and/or wage-loss benefits. Select one or both, as applicable:

□ Initial claim for whole-person impairment

□ Initial claim for wage-loss benefit

Date of initial wage-loss from accepted illness _____/_____(Month/Year)

Period of wage-loss claimed ____/____ (Month/Year TO: ____/____(Month/Year)

Option B – I have previously received an award for impairment and/or wage-loss because of my accepted condition(s). This claim is for **increased** whole-person impairment and/or **additional** wage-loss. For increased impairment, it has been at least 2 years since my last award. For additional wage-loss, it has been one year since my last award. Select one or both, as applicable.

□ Claim for increased whole-person impairment

□ Claim for additional wage-loss benefit

6. For Impairment Claims – identify the physician you would like to perform your impairment evaluation: (Select only one)

□ DEEOIC will arrange for a qualified physician, known as a Contract Medical Consultant (CMC), to perform the impairment evaluation.

□ A physician of my choosing will perform my whole person impairment.

Physician Name:_____

Address:_____

Phone Number:_____

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. If applicable, I authorize the Department of Justice to release any requested information, including information related to my RECA claim, to the U.S. Department of Labor, Office of Workers' Compensation Programs (OWCP). Furthermore, 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.

_____ Employee Signature

_____ Date

Instructions for Completing Form EE-10

Impairment: "Whole-person impairment" (or "impairment") is a percentage rating that represents the extent of impairment of a person based on the organ(s) and or system(s) affected by the accepted illness(es). The percentage of impairment reflects how severely your accepted illness(es) affect your body as a whole. The available monetary benefit is $2,500 for every percentage point, up to a maximum monetary award of $250,000 under Part E. An impairment rating must be performed by an appropriate physician once your accepted illness has reached maximum medical improvement, meaning that it is unlikely to improve with additional treatment. In order for a physician to be considered able to perform impairment evaluations under EEOICPA, the physician must hold a valid medical license and Board certification (or eligibility) in an appropriate field of expertise. The physician must also be certified by the American Board of Independent Medical Examiners or the International Academy of Independent Medical Evaluators or possess the requisite professional experience and medical work background in interpreting the American Medical Association's *Guides to the Evaluation of Permanent Impairment (*AMA's *Guides*) to provide such ratings**.**

An employee previously awarded impairment benefits may file a claim for increased impairment benefits for the same covered illness included in the previous award. The employee may not submit a claim form for an increased impairment rating earlier than two years from the date of the last final decision on impairment. A waiver of the two-year waiting period may be granted if:

(1) A new covered illness has been accepted since a previous final decision awarding impairment and the condition relates to an organ system that was not included in a prior rating.
(2) The claimant requests a waiver of the two-year rule and submits medical evidence, documenting since the last impairment rating, that the accepted condition(s) has caused a substantial detrimental effect to the claimant's living circumstances, one or more ADLs, or medical status.

Wage-Loss: (1) are awarded if the accepted illness(es) caused or contributed to an employee's loss of earnings; and (2) are payable only for the calendar years of wage-loss experienced before an employee's normal Social Security retirement age. A person's normal retirement age is based on the year when he/she was born and is usually 65 years of age but can be as high as 67 years of age (see the enclosed Social Security Retirement Age Table). Wage-loss benefits are payable only through the calendar year when normal retirement age is reached. In addition, earnings and medical documentation must be submitted to support the period of wage-loss being claimed.

Complete all the applicable items on the form. 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 applicable 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/DEEOIC
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 E of EEOICPA.
Item 5 – Mark the appropriate box to specify whether you are claiming initial impairment or wage-loss, or increased impairment or additional wage-loss benefits. For wage-loss enter the month and year the initial wage-loss began and the period you are claiming wage-loss (i.e., January/2001 to December/2006). An initial claim means the first time you are filing for benefits, either impairment, wage-loss, or both. An increased claim means you have previously been awarded impairment or wage-loss benefits, the required elapsed time has passed (2 years for impairment, 1 year for wage-loss), and you are now filing a subsequent claim to determine whether you have an increase in impairment or whether you have another year of wage-loss.

Item 6 – Only one option may be selected. Mark the appropriate box to specify whether you would like DEEOIC to submit your claim to a CMC for a medical records evaluation. If you select this option you will need to submit an Activities of Daily Living Form, along with the previous 12 months of medical records pertaining to the claimed illness(es). If you select a physician of your choice you must provide their name, address, and telephone number. Your physician of choice must be qualified to conduct an impairment evaluation as stated above.

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. 1240-0002. **Do not submit the completed form to this address.**