File Number: XXXXXXXXX
CA-1032-FO-CA1032
OMB No: 1240-0016
Expiration Date: 11-30-2026

U.S. DEPARTMENT OF LABOR

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

Want Faster Service?
Upload a document at ecomp.dol.gov

<<Date>>

Date of Injury: <<DOI>>
Employee: <<Claimant>>

<Address>

Dear: <CLAIMANT>

The information requested in this letter is required in connection with your ongoing 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 (including volunteer work), 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.

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.

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 you need more space to fully answer any of the questions, include separate correspondence.

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.

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.

Sincerely,

Federal Employees Program

Enclosure(s): EN1032

<EMPLOYING AGENCY ADDRESS>

File Number: 550647720
CA-1032-FO-CA1032
OMB No: 1240-0016
Expiration Date: 11-30-2026

Part A: Employment

Review the **enclosed instructions** referencing what must be reported before answering the questions below.

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

1. You must report work over the last 15 months for any employer to include self-employment, any involvement in any business enterprise, and/or any volunteer work regardless of whether compensation was received. Did you work or volunteer?

☐ No. Proceed to Part B: Dependents

☐ Yes. Respond to the remaining questions below and attach your most recent earnings statement to include your current rate of pay, your annual earnings and/or any in-kind compensation received to date and your employer's name and address.

2. Select any that apply: ☐ Employed ☐ Volunteer work ☐ Self-Employed

3. Beginning and ending dates of any employment, and/or volunteer work:

_____
___

4. Frequency of work done (hours per week, weeks per month, etc):

_____
___

5. Describe the kind of work done:

_____
___
_____
_____
_____

6. Rate of pay: $_____hr/wk/mo/yr Actual earnings: $_____

File Number:
CA1032-FO-CA1032
OMB No: 1240-0016
Expiration Date: XX

Part B: Dependents. Review the **enclosed instructions** referencing who is considered an eligible dependent before answering the questions below. You must answer the questions to ensure your compensation is paid at the correct rate. You are required to report changes in dependents as soon as those changes occur.

1. Do you have a dependent as defined in the enclosed instructions? ☐ Yes ☐ No

2. If yes, list each dependent by name, their date of birth and the dependent type (as defined in a through f in the enclosed instructions). If you have no dependents, skip this question.

Dependent Name	Date of Birth	Dependent Type (a through f)
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you have additional dependents to add, list them on a separate sheet of paper, include your name and claim number at the top, and sign and date each extra sheet.

For any claimed student dependent (unmarried child between 18 and 23 who is a full-time student), submit a copy of the most recent transcript, or other documentation from the educational institution, sufficient to demonstrate that the student is currently attending on a full-time basis. Include your name and claim number at the top of the document, along with the expected date of graduation, and sign and date the document.

Part C: Other Federal Benefits or Payments. This section is to report any benefits you receive from any other Federal disability or retirement system other than FECA. **DO NOT report benefits received under the FECA.**

1. **Office of Personnel Management (OPM) Benefits**. Report any disability or retirement benefits you receive from OPM. 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.

a. Have you been assigned a CSA number? ☐ Yes ☐ No
If yes, write it here: _____
b. During the past 15 months, have you received a payment from OPM? ☐ Yes ☐ No

File Number:
CA1032-FO-CA1032
OMB No: 1240-0016
Expiration Date: XX

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

a. Are you receiving any benefits from the SSA? ☐ Yes ☐ No
b. If yes, indicate:
Benefit type: ☐ Retirement ☐ Disability
Retirement system: ☐ FERS ☐ CSRS ☐ Other _____

3. **Department of Veterans' Affairs (VA) Benefits**.

a. Do you receive benefits from the VA on account of service in the Armed Forces? ☐ Yes ☐ No
b. If yes, indicate:
VA File Number _____
Nature of Disability _____
Has the percentage of your VA award increased since the injury for which you are receiving benefits under the FECA? ☐ Yes ☐ No If yes, date of increase _____

Attach your most recent award letter from the VA that shows the conditions for which your benefits are paid, the percentage of impairment awarded, the date of the award, and the date of any increase.

4. **Other Benefits.** Report any other benefits paid by the Federal government **not** including benefits under the FECA. Also report the receipt of any state benefits such as state workers compensation benefits or Unemployment Compensation during the period covered by this form. Such benefits may be offset or reduced for FECA benefits received.

Have you received any other Federally funded or assisted benefits or other state benefits such as described above? ☐ Yes ☐ No

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

Type of Claim/Award/Benefit: _____
Agency and Address: _____
_____
Claim or File No.: _____

Part D: Third Party Settlement. In the past 15 months, did you receive any settlement or award from a claim or suit (insurance, legal or otherwise) 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 ☐ No

If yes, provide a copy of any settlement or award notice you have been issued relating to the verdict of your claim or suit. Such notice must include the date of the judgement or settlement, the party or parties involved, the type of suit or settlement, and the amount of judgement or settlement.

If you were represented by counsel in your claim or suit against a third party, please provide your attorney's information:

File Number:
CA1032-FO-CA1032
OMB No: 1240-0016
Expiration Date: XX

Name _____
Firm:_____
Address:_____
Email address_____

)

File Number:
CA1032-FO-CA1032
OMB No: 1240-0016
Expiration Date: XX

Part E. 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 ☐ 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 ☐ No

If yes, place and dates of incarceration:_____

—Part F: Corrections.

The name and address we have on file for you are shown below.

Name: <<Name>>
Address: <<Address>>

Is the above information correct? ☐ Yes ☐ No

If no, provide updated information below:

Name: _____
Address: _____
_____

Part G: 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 (FECA) 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

PUBLIC BURDEN STATEMENT

The OMB control number for this collection is 1240-0016 and expires on 11/30/2026.

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.

Instructions: Form EN1032

Part A Employment:

- **If you have questions about whether something is material or relevant and should be included, provide 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.**

- **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. 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. Volunteer work where no payment was received should also be reported.

- **Report ALL self-employment or involvement in business enterprises.** This includes but is 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, ride share or other delivery services, 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 do not need to list ownership or passive investment in any publicly traded businesses. You do not need to list stocks or bank accounts.

Part B Dependents:

A dependent is defined as any of the following:

a. Spouse who lives with you
b. Unmarried child, including an adopted child or stepchild, who lives with you and is under 18 years of age
c. Unmarried child who is 18 or over, but who cannot support himself or herself because of mental or physical disability
d. 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. Parent who totally depends upon you for support
f. Spouse or child who does not live with you if a Court has ordered you to pay support to that person

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.