

Date
Case ID Number:

Employee Name:

CLAIMANT NAME
STREET ADDRESS
CITY, STATE ZIP

Dear :

The information requested in the attached enclosure is required in connection with your claim for benefits under the Energy Employees Occupational Illness Compensation Program Act of 2000 (EEOICPA). This information will be used to decide if you are entitled to benefits, and if so, the level of those benefits. The Division of Energy Employees Occupational Illness Compensation (DEEOIC) will not be able to process your claim for benefits without this information. You must completely answer all questions and return the enclosure within 30 days of the date of this letter to the following address:

U.S. Department of Labor OWCP/DEEOIC
PO Box 47050
San Antonio, TX 78265

You may also FAX the completed enclosure to:

Pub. L. 100-503 provides that the statements on the enclosure and other information in your claim file may be verified through computer matches. DEEOIC may also ask that you submit any factual evidence it deems necessary to support your statements.

If you have a disability (a substantially limiting physical or mental impairment), please contact our office for information about the kinds of help available, such as communication assistance (alternate formats or sign language interpretation), accommodations and modification.

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READ ALL INSTRUCTIONS CAREFULLY BEFORE FILLING OUT THE ENCLOSED EN-16. 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 ID 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 BENEFITS AND SUBJECT YOU TO CIVIL LIABILITY. A FRAUDULENT ANSWER MAY RESULT IN CRIMINAL PROSECUTION. ALL STATEMENTS ARE SUBJECT TO INVESTIGATION FOR VERIFICATION.

Your signature certifies that you have supplied all information requested by the enclosure. If you have any questions about completing the enclosure, call me at {(xxx)xxx-xxxx} or write to me at the address given above.

Sincerely,

Name
Title
District Office

Enc: Form EN-16

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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) Disclosure of your social security number (SSN) or tax identification

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number (TIN) is mandatory. We are authorized to collect your SSN or TIN under Executive Order 9397 (November 22, 1943). Your SSN or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (7) 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 20 minutes per response, including time for reviewing instructions, searching existing data sources, gathering the data needed, and completing and reviewing the collection of information. The obligation to respond to this collection is required to obtain EEOICPA benefits (20 CFR 30.505). Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them 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 and Form EE/EN-16. **Do not submit the completed form to this address.**

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Case ID Number:

Claimant Name:

PART A – TORT SUITS FILED AGAINST BERYLLIUM VENDORS OR ATOMIC WEAPONS EMPLOYERS

1. Have you filed a tort suit (other than an administrative or judicial proceeding for workers' compensation) against a beryllium vendor or atomic weapons employer related to an exposure for which you would be eligible to receive compensation under EEOICPA? Yes or No: _____

2. If Yes, state:

Date of filing: _____

Party or parties involved: _____

Date tort suit was dismissed: _____

List any other tort suits on an extra sheet.

PART B – THIRD PARTY SETTLEMENTS OR AWARDS

1. Have you received any settlement or award from a claim or suit (other than a claim for workers' compensation) against a third party (other than a beryllium vendor or atomic weapons employer listed in Part A above) related to an exposure for which you would be eligible to receive compensation under EEOICPA? Yes or No: _____

2. If Yes, state:

Date of judgment or settlement: _____

Party or parties involved: _____

Type of suit or settlement: _____

Amount of award or settlement: _____

List any other third party settlements or awards on an extra sheet.

PART C – STATE WORKERS’ COMPENSATION

1. Have you filed for or received any state workers’ compensation benefits on account of your claimed illness(es)? Yes or No: _____

2. If you answered “Yes,” please tell us the following information:

Date of filing: _____

State in which you filed: _____

Illness(es) for which you received benefits: _____

Name of employer, insurer or state that paid: _____

Amount of monetary benefits received: \$ _____

Type of benefits (disability, impairment, etc.): _____

PART D – FRAUD CHARGES

1. Have you either pled guilty to or been convicted on any charges of having committed fraud in connection with an application for or receipt of benefits under EEOICPA or any other federal or state workers’ compensation law? Yes or No: _____

2. If Yes, state:

Date of conviction or guilty plea: _____

Jurisdiction where fraud charges were brought: _____

PART E – SURVIVORS OF DECEASED EMPLOYEES

1. Are you claiming compensation under EEOICPA as a survivor of a deceased employee? Yes or No: _____

2. If Yes, state:

Your relationship to the deceased employee: _____

If spouse, list date and place of marriage: _____

If other than spouse, list your date of birth: _____

3. Do you know of any other persons who may also be eligible to receive compensation under EEOICPA as a survivor of the deceased employee upon whom your claim is based? Yes or No:_____

4. If Yes, state:

Name of other survivor: _____

Relationship of other survivor to deceased
employee: _____

Address and/or telephone number of other survivor (if
known): _____

List any other survivors on an extra sheet.

PART F – CORRECTIONS

If the name, address, Case ID Number or telephone number shown at the top of the first page of the accompanying letter is incorrect, provide the correct information in the space provided below. (Do not complete if the information is correct).

Name: _____

Case ID Number: _____

Address: _____

Telephone Number: _____

PART G – CERTIFICATION

I know that anyone who fraudulently conceals or fails to report information that 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 EEOICPA may be subject to criminal prosecution, from which a fine and/or imprisonment may result.

I understand that I must immediately report to DEEOIC any tort suit or state workers' compensation settlement I receive, any tort suit I file against a beryllium vendor or atomic weapons employer, any change in the status of a survivor, and any conviction for fraud committed against this program or any other federal or state workers' compensation law.

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