U. S. Department of Labor

Office of Workers' Compensation Programs
Washington, D.C. 20210

OMB NO: 1240-0013
Expiration Date: 12-31-2019

Sender Address:
Phone:

Date:

Date of Injury:
Employee:

To Address:

Dear:

Additional information is needed in support of your claim for dependency compensation. Please supply answers to all questions on the attached questionnaire and complete the affidavit which follows.

Further consideration will be given to your claim on receipt of this evidence. This information is required to obtain a benefit (5 U.S.C. 8101 et seq.).

Sincerely,

Name of Signer:
Title:

CC Addresses:

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

EVIDENCE REQUIRED IN SUPPORT OF A DEPENDENCY CLAIM

1. State the inclusive dates the deceased was employed during the 12 months immediately preceding death. Give the names and addresses of his employers during that period, the rate of pay, and the total amount earned in each job.

2. State whether the deceased was living away from home at any time during the 12-month period before death. If so, give the inclusive dates. Forward any canceled checks, money order receipts, letters, or other evidence of the fact that the deceased contributed to your support during that time.

3. If you are now employed, give your Social Security account number, the name of your employer, your wages, and your occupation. If not now employed, explain why.

4. State whether your husband (or wife) survives. If he is employed, give his Social Security account number, employer's name, amount of wages, and occupation. If not employed, state why.

5. Furnish names and relationship to you of all persons who lived in the same household with you during the year preceding the death, and the monthly amount contributed by each toward support of the household.

6. State what support you have received from your surviving children since the death of the decedent. If they are now living with you and are not contributing to your support, state why.

7. List all real or personal property owned by you and your husband (wife), including money on deposit in the bank or invested, and the income from all property and investments.

8. Submit a copy of the record of birth of the deceased.

9. Submit an affidavit from at least two persons (preferably not related to you or to the decedent) who have actual knowledge of whether the decedent contributed to your support during the 12 months before death; whether you were dependent on these contributions for your livelihood; why this was true and how they (the affiants) know it to be true.

I certify that the information give in response to his questionnaire is true to the best of my knowledge and belief. I further understand that any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both.

_____ _____

Signature Date

Public Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. Public reporting burden for this collection of information estimated to be 60 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the date needed, and completing and reviewing the collection of information. The authority for requesting this information is 5 U.S.C. 8101 et seq. The information will be used to determine entitlement to benefits. Furnishing the requested information is required for the claimant to obtain or retain a benefit. Send comments regarding the burden estimate or any aspect of this collection of information, including suggestions for reducing this burden, to the Office of Workers' Compensation Programs, Department of Labor, Room S-3229, 200 Constitution Avenue, NW, Washington, DC 20210, and reference the OMB Control Number 1240-0013.
Note: please do not send the completed form to this office; rather, send it to the address shown on the letterhead.