Date

Name
Address
City, State ZIP

Case ID Number:

Dear :

This letter is in reference to your claim under Part E of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

Our records indicate that you received a prior award under Part E of EEOICPA for impairment and/or wage-loss as a result of an accepted work-related illness. The rules governing the administration of the Energy program allow for an individual to seek additional benefits after a certain period of time has elapsed since a prior award of benefits. The attached EN-10 is used to claim those additional benefits. However, to claim additional benefits using the EN-10, you must be aware of the following:

WAGE-LOSS – A claim for additional wage-loss benefits may only be submitted if at least one year has elapsed since you were previously awarded benefits for wage-loss in a final decision. In addition, eligibility is based on qualifying wage-loss sustained in calendar year increments as a result of the accepted illness. If you claim for additional wage-loss benefits due to an accepted illness, development will be initiated to obtain the evidence necessary to show that you have sustained additional wage-loss due to your accepted illness. This will include obtaining financial and medical documentation from you in support of the claim. You cannot seek benefits for calendar years of wage-loss that have been addressed previously by a final decision.

IMPAIRMENT – A claim for increased permanent impairment benefits may only be submitted if at least two years has elapsed since you were last awarded impairment benefits in a final decision. If you claim for additional impairment benefits, development will commence to determine the extent to which your accepted illness has resulted in an increased permanent impairment of the whole body. This will require a medical examination by an appropriate physician, and a review of up-to-date medical documentation.

The attached EN-10 should be completed only if you are pursuing additional wage-loss or impairment benefits and can obtain the evidence necessary to establish your claim. You may claim additional wage-loss and impairment at the same time. If you choose to file for additional benefits, mail the enclosed EN-10 to the following address:

U. S. Department of Labor DEEOIC Central Mailroom
P.O. Box 47050
San Antonio, TX 78265

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.

If you are not interested in filing a claim for additional benefits at this time, take no action with regard to this letter. Should you have questions about completing the EN-10, please contact your district office at (Insert Number)

Sincerely,

Name
Title
Office

Enclosure: EN-10

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 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 5 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 30.102). 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-10. **Do not submit the completed form to this address.**

Claim for Additional Wage-Loss and/or Impairment Benefits 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: Please review all instruction relating to this form before completing. Sign and date the bottom of the page.	OMB Control No: 1240-0002 Expiration Date: 03/31/2022

Employee's Information (print clearly)

1. Name (Last, First, Middle Initial)	**2. Social Security Number**
3. Address (Street, Apt. #, P.O. Box)	**4. Telephone Number(s)** a. Home: ( ) -
(City, State, ZIP Code)	b. Other: ( ) -

Additional Compensation Claimed: (check one or both boxes)

☐ **Wage-Loss** – I hereby claim additional wage-loss benefits as a result of my accepted work-related illness. It has been at least one year from the date of a prior final decision awarding me wage-loss benefits. As a result of this claim, I realize that I will be expected to provide the evidence necessary to support that I have sustained additional wage-loss in one or more calendar year(s). My claim does not include years of wage-loss addressed by a previous final decision.

☐ **Impairment** – I hereby claim increased permanent impairment benefits as a result of my accepted work-related illness. It has been at least two years from the date of a prior final decision awarding me benefits based on a percentage of whole person impairment. As a result of this claim, I realize that I will be expected to provide medical evidence that supports an increased impairment. This may include obtaining updated diagnostic evidence, along with an updated medical examination by an appropriate physician.

Declaration of the Person Completing this Form

Any person who knowingly makes any false statement, misrepresentation, concealment of fact of 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. In addition, a felony conviction will result in termination of all current and future EEOICPA benefits. I affirm that the information provided on this form is accurate and true.

(Signature) (Date)

Resource Center Date Stamp