Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

OMB No. 1215-0155
Expires: 04-30-98

1. Name of deceased employee (Last, first, middle)	2. Date of Birth (Mo., day, year)	3. Date of Injury (Mo., day, year)	4. Date of Death (Mo., day, year)	5. Social Security Number

6. Name and address of employing agency (Include ZIP Code)	7. Nature of injury which caused death

8. Name of dependent (Last, first, middle)	9. Dependent's address (Include ZIP Code)	10. Dependent's birth date (Mo., day, year)

11. Dependent's Occupation	12. Dependent's Social Security Number	13. **Dependent's relationship to employee**	14. **Extent of dependency on employee** ☐ Total ☐ Partial

15. Total amount employee contributed to dependent's support during 12 months immediately prior to death.	16. Did employee live with dependent during the 12 months immediately prior to death? ☐ Yes ☐ No If "Yes", Complete 17 & 18.	17. Total amount employee paid dependent in mone or service for room and boardytn addition to amount shown in 15.	18. If no fixed **amount was** paid for room and board, what is the fair value of such room and board?
$ _____		$ _____ Per _____	s _____ Per _____

19. If dependent was employed during 12 month period prior to employee's death, gave:

Type of work performed:

Period of employment:

Monthly pay rate:

Name and address of employer:

20. Show dependent's income from all sources other than employment during 12 month period prior to employee's death:

Investments	$
Pensions	
Persons other than employee	
Other	_____
Total	$

Information about dependent's husband or wife (Items 21 through 25)

21. Birth Date (Mo., day, year)	22. Occupation	23. **Monthly pay rate**	24. **Total** income from all sources for 12 months prior to employee's death.
		$ _____	$ _____

25. List all property owned by dependent and husband or wife (omit clothing, furniture, personal items).

Description	Date Acquired	Value

26. If an application has been made for U.S. Civil Service Annuity or any other Federal Retirement or Disability Law because of employee's death, give:

Retirement System: ☐ CSRS ☐ FERS ☐ SSA ☐ Other

Claim number for each claim: a. _____ b. _____

Date each benefit began: a. _____ b. _____

Amount of each benefit paid per month: $ a. _____ b _____

27. If an application has been made for Veterans Administration (VA) benefits because of employee's death, give:

Service number: VA **Claim number:**

Address of VA office where claim is filed:

28. If a claim has been made against a third party because of employee's death, give:

Amount of recovery: $ _____

Name and address of third party:

29. Total burial expense	30. Amount of burial expense paid or payable by VA	31. Name and address of party (other than VA) whose funds were used to pay burial expense and amount paid:
$ _____	$ _____	$ _____

I hereby certify that each and every statement made above is true to the best of my knowledge. 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.

32. Signature of person filing claim	33. Address (Include ZIP Code)	34. **Date (Mo., day, year)**

Attending Physicians Report

1. Name of deceased employee (Last, first, middle)

2. Date of death (MO., day, year)

3. What history of injury or employment related disease was given to you?

4. If treated for disease, give diagnosis.

5. If death was not instamaneous describe the treatment you provided.

6. Show dates on which treatment was given.

7. What was the direct cause of death?

8. What were the contributory causes of death, if any?

9. In your opinion, was the death of the employee due to the injury as reported in item 3 **above?** ☐ Yes ☐ No
Give the medical reasons for your opinion, unless causal relationship is obvious.

10. Was a biopsy or an autopsy performed?
Arrange for a copy of the report to be submitted. ☐ Yes ☐ No

11. Name and address (**Please** type - include ZIP Code)

I certify that all statements in response to the questions asked abovo are true, complete and correct to the best of my knowledge Further, I understand that any knowingly false or misleading statement or concealment of material fact may subject me to criminal prosecution.

12. Signature

13. Date signed (Mo., day, year)