Claim for Continuance of Compensation Under the Federal Employees' Compensation Act

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

OMB No. 1215-0154
Expires: 05-31-05

INSTRUCTIONS TO BENEFICIARIES

1. It is important that you carefully complete the other side of this form and return it to the OWCP within 30 days. Your failure to do so will result in suspension of the compensation you are receiving.
2. Complete Section A by printing the full name of the deceased employee and the OFFICE OF WORKERS' COMPENSATION PROGRAMS file number.
3. Answer all questions in the section or sections that apply to you. If you are receiving compensation as the:
   (A) WIDOW OR WIDOWER Complete Section B.
   (B) WIDOW OR WIDOWER RECEIVING COMPENSATION ON HER OR HIS ACCOUNT AND ON ACCOUNT OF A MINOR CHILD OR CHILDREN - Complete Sections B and C.
   (C) GUARDIAN OR CUSTODIAN OF A MINOR CHILD OR GRANDCHILD OR A PERSON INCAPABLE OF SELF-SUPPORT - Complete Section C.
   (D) PARENT, GRANDPARENT, OR A PERSON WHO IS PHYSICALLY INCAPABLE OF SELF-SUPPORT - Complete Section D.
   (E) Complete Block C if dependent is receiving educational benefits.
4. Carefully read and comply with directions in Section E.
5. Complete and sign the certificate in Section F.
6. Please return the completed form, in an envelope, to the address shown below.

The information on this form will be used to determine your eligibility for continuing benefits. Your response to this information is required to retain your compensation benefits. (20 CFR 10.126)

RETURN TO: U.S. DEPARTMENT OF LABOR, DFEC
CENTRAL MAILROOM
P.O. BOX 8300
LONDON, KY 40742-8300

Privacy Act

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a) and the Computer Matching and Privacy Protection Act of 1988 (Public Law No. 100-503), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the Office receives and maintains personal information on claimants and their immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information collected by this form and other information collected in relation to your compensation claim may be verified through computer matches. (4) The information may be given to Federal, State, and local agencies for law enforcement and for other lawful purposes in accordance with routine uses published by the Department of Labor in the Federal Register. (5) Failure to furnish all requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits. (Disclosure of a social security number (SSN) is required by P.L. 103-296 108 Stat. 1464. Your SSN may be used to request information about you from employers and others who know you, but only as allowed by law or Presidential directive. The information collected by using your SSN may be used for studies, statistics, and computer matching to benefits and payment files.)

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB number.

Public Burden Statement

We estimate that it will take an average of 5 minutes per response to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.

Reset Print

IMPORTANT: READ CAREFULLY THE INSTRUCTIONS ON THE OTHER SIDE OF THIS FORM BEFORE ANSWERING THE QUESTIONS BELOW

I HEREBY APPLY FOR CONTINUANCE OF COMPENSATION BENEFITS AWARDED TO ME (OR TO THE CLAIMANT ON WHOSE BEHALF I AM NOW ACTING) BY THE OFFICE OF WORKERS' COMPENSATION (OWCP) ON ACCOUNT OF THE DEATH OF:

A. Name of Deceased Employee	Employee's Federal Retirement Plan	OWCP File No.
	☐ CSRS ☐ FERS ☐ Other	

THIS BLOCK TO BE COMPLETED BY WIDOW/WIDOWER RECEIVING COMPENSATION

B. 1. Have You Married since the Death of Above Named Employee? ☐ Yes ☐ No (If "Yes" complete 10)

2. Do You Receive a Pension or Allowance from any other Federal Agency such as the Veterans' Administration, Social Security Administration or the Civil Service Commission on Account of the Death of this Employee? ☐ Yes ☐ No (If "Yes" complete 11)

THIS BLOCK TO BE COMPLETED BY ANY PERSON RECEIVING COMPENSATION ON BEHALF OF CHILD GRANDCHILD, OR DEPENDENT INCAPABLE OF SELF-SUPPORT

C. 3. Have any Dependents You Claim Compensation for Married Since the Death of the Above Named Employee? ☐ Yes ☐ No (If "Yes" complete 10)

4. Do Any Dependents You Claim Compensation for Receive a Pension or Allowance from Any Other Federal Agency Such as the Veterans' Administration, Social Security Administration, or the Civil Service Commission on Account of the Death of this Employee? ☐ Yes ☐ No (If "Yes" complete 11)

5. Give the Following Information for Each Person You Receive Compensation For:

NAME	AGE	IS PERSON IN YOUR CUSTODY? (Yes or No)	NAME, ADDRESS, AND RELATIONSHIP OF PERSON(S) HAVING CUSTODY IF NOT IN YOUR CUSTODY

THIS BLOCK IS TO BE COMPLETED BY PARENT, GRANDPARENT, OR DEPENDENT PHYSICALLY INCAPABLE OF SELF-SUPPORT

D. 6. Have You Married Since the Death of the Above Named Employee'? ☐ Yes ☐ No (If "Yes" complete 10)

7. Do You Receive a Pension or Allowance from any other Federal Agency such as the Veterans' Administration or the Civil Service Commission on Account of the Death of this Employee? ☐ Yes ☐ No (If "Yes" complete 11)

8. Are You Capable of Self-Support? ☐ Yes ☐ No

9. Have You Been Employed Since Filing Your Last Claim Form? ☐ Yes ☐ No (If "Yes" complete 12)

ADDITIONAL INFORMATION: THIS BLOCK TO BE COMPLETED ONLY WHEN AN ANSWER TO 1, 2, 3, 4, 5, 6, 7, or 9 IS "YES."

E.	(Space for Answers to questions 10, 11, and 12)
10. When and Where was the Marriage Performed and What was the Change in Name, If Any?	
11. What Agency is Paying the Benefits and For What Reason Are They Being Paid?	
12. State the Name of Your Employer, Nature of Employment, Dates Employed, and Amount Earned.	

CLAIMANT'S CERTIFICATION - TO BE COMPLETED IN ALL INSTANCES

F. I DECLARE UNDER THE PENALTIES OF PERJURY THAT THE INFORMATION CONTAINED ON THIS FORM IS TRUE AND CORRECT: AND THAT I WILL IMMEDIATELY NOTIFY THE OFFICE OF WORKERS' COMPENSATION PROGRAMS OF ANY CHANGES IN STATUS.

Signature of Claimant (or guardian)	Date (month, day, year)
Address of Claimant (or guardian)	Telephone Where You Can Be Reached
Signature of Witness and Date Witnessed if Claimant Signs by Mark (X)	