Claim for Survivor Benefits under Energy Employees Occupational Illness Compensation Program Act

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

Provide all information requested below. **DO NOT FILL IN SHADED AREAS**. Disclosure of your social security number is voluntary. Failure to disclose this number will not result in the denial of any right, benefit or privilege to which you may be entitled.

OMB No.:
Expires:

SURVIVOR INFORMATION

1. Name *(Last, First, Middle Initial)*
2. Social Security Number
3. Date of Birth (Month Day Year)
4. Address *(Street, Apt #, P.O. Box)*
5. Sex ☐ Male ☐ Female

(City, State, ZIP Code)

6. Telephone Number ( ) –

7. What was your relationship to the deceased employee at the time of his/her death? (Spouse, dependent child, grandparent, sibling, etc.)

DECEASED EMPLOYEE INFORMATION

8. Name *(Last, First, Middle Initial)*
9. Social Security Number
10. Sex ☐ Male ☐ Female
11. Date of Birth (Month Day Year)
12. Date of Death (Month Day Year)
13. Was an autopsy performed on the employee? ☐ YES List medical facility _____ ☐ NO

14. Identify Claimed Condition(s) Present at Date of Death		15. Date of Diagnosis Month	Day	Year	FOR DOL USE ONLY	
☐ Cancer	Specify Type					
☐ Chronic Beryllium Disease						
☐ Chronic Silicosis						
☐ Other Lung Condition	Specify Type					
☐ Renal Disease	Specify Type					

16. Identify location or type of employment performed by the deceased employee *(Mark any that apply)*:

☐ **Department of Energy Facility**
This is defined as any building, structure or premise in which the activities of federal employees, contractors or subcontractors have been conducted by or on behalf of the Department of Energy.

☐ **Atomic Weapons Facility**
This is defined as a privately-owned facility in which radioactive material has been processed for use by the United States in the manufacture of atomic weapons. (Excludes mining, milling, or transporting uranium ore.)

☐ **Beryllium Vendor**
This is defined as any privately operated entity engaged in producing or processing beryllium for sale or use by the Department of Energy.

☐ **Uranium Worker**
This is defined as employment activity associated with the mining, milling or transportation of uranium ore for use in the manufacture of atomic weapons.

SPECIAL EXPOSURE COHORT

17. Prior to February 1, 1992, did the deceased work at a gaseous diffusion plant in Paducah, Kentucky; Portsmouth, Ohio; or Oak Ridge, Tennessee?
☐ YES If yes, which site(s) _____ ☐ NO

18. Prior to January 7, 1974, did the deceased work at the Long Shot, Milrow, or Cannikin underground nuclear tests on Amchitka Island, Alaska?
☐ YES If yes, which site(s) _____ ☐ NO

19. Was the deceased a member of a group added to the Special Exposure Cohort by the Department of Health and Human Services?
☐ YES List group designation _____ ☐ NO ☐ DON'T KNOW

RADIATION EXPOSURE COMPENSATION ACT AWARD & LAWSUIT

20. Have you or the deceased received an award letter under the Radiation Exposure Compensation Act?
☐ YES If yes, submit a copy of your award letter ☐ NO

21. Did the deceased or you file a civil lawsuit regarding the claimed condition(s)?
☐ YES If yes, submit a copy of court documentation ☐ NO

SURVIVOR DECLARATION

22. Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided under the 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. I hereby make a claim for benefits under the Energy Employees' Occupational Illness Compensation Program Act and affirm that the information I have provided on this form is true. Furthermore, I authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the United States Department of Labor, Office of Workers' Compensation Program.

Claimant Signature _____ Date _____

EE-2
May 2001

BENEFITS FOR SURVIVORS UNDER ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT

The Energy Employees Occupational Illness Compensation Program Act (EEOICPA) provides for a lump sum payment of $150,000 to eligible survivors of a covered employee who at the time of death had a designated illness incurred as a result of exposure to radiation, beryllium, or silica while in the performance of duty for the Department of Energy and certain of its vendors, contractors and subcontractors. This legislation also provides for a lump sum payment of $50,000 to certain survivors of deceased covered employees, who were found eligible for compensation under the Radiation Exposure Compensation Act.

DEFINITION OF SURVIVOR UNDER THE ACT

Entitlement to any lump-sum payment for survivor(s) under the EEOICPA will be determined as of the time of death of the covered employee. In order to be considered an eligible survivor under the EEOICPA, you must be a widow or widower, child, parent, brother, sister, grandparent or grandchild of a deceased covered employee. ***(Attach a copy of marriage license; birth certificate; or adoption papers demonstrating proof of relationship to deceased.)*** This does not include:

a. a child, brother, sister, or grandchild who, at the time of death, was married or 18 years of age (unless incapable of self support); or
b. a parent or grandparent who, at the time of death, was not dependent on the deceased covered employee.

An unmarried child, brother, sister, or grandchild is a survivor if he/she was, at the time of death, enrolled as a full-time student at an accredited college or university and under the age of 23.

INSTRUCTIONS FOR COMPLETING FORM EE-2

Complete all items on the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. If the requested information is not submitted, the responsible party should explain the reason for the delay and indicate when the information will be forthcoming. Submit the completed claim form and all other pertinent documentation to the appropriate District Office administering the EEOIPCA in the region where your most recent energy employer is/was located.

Deceased Employee Information

Item # 14 — Identify the condition the deceased employee suffered prior to their death (Attach a copy of the employee's death certificate to the claim form). It is not necessary to establish that the death was caused by the claimed condition. Rather, the evidence must demonstrate a qualified physician diagnosed a covered condition prior to death.

Item #16 — Mark location or type of work activities that best describe the deceased employee's work situation. If more than one of the listed categories applies, indicate such on the form. The Department of Energy has also compiled a list of covered facilities. The list is available at ***http://tis.eh.doe.gov*** or by contacting the Office of Workers' Compensation Programs.

If you are aware of any person who may qualify as a survivor of the deceased, notify the Office of Workers' Compensation in writing.

Special Exposure Cohort

Items #17–18 — The Act allows for employees who have met particular criteria and have been employed at certain facilities to be designated as members of the Special Exposure Cohort. If the deceased employee worked at any of the listed locations prior to the dates indicated, mark YES and identify the site name.

Item #19 — The Act permits the Department of Health and Human Services (HHS) to include new groups of employees in the Special Exposure Cohort. If you can identify the deceased employee as a member of a designated group that has been added to the Special Exposure Cohort, mark YES and describe the group in which he/she belonged.

Radiation Exposure Compensation Act Award & Civil Lawsuit

Item #20 — If you or the deceased have been found entitled to an award under the Radiation Exposure Compensation Act, you may be eligible for additional payment under the EEOICPA. Please indicate whether or not you or the deceased have received a notice of award under the RECA. If you mark YES, you will need to submit a copy of the award letter.

Item #21 — Indicate whether you or the deceased ever filed a civil lawsuit in regards to the claimed condition. If you mark YES, provide copies of all court documentation.

PRIVACY ACT

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 (P.L. 106-398) (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 which the Office has will be used to determine eligibility for, and the amount of, benefits payable under the EEOICPA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agencies or private entities which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider other relevant matters. (4) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical rehabilitation, making evaluations for the Office 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 the EEOICPA, to determine whether benefits are being paid properly, including whether prohibited payments have been made, and, where appropriate, to pursue salary/administrative offset and debt collections actions required or permitted by the Debt Collection Act. (6) 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. This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the EEOICPA.

PUBLIC BURDEN STATEMENT

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering data needed, and completing and reviewing the collection of information. If you have any comments regarding the 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 S3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Do not submit the completed claim to this address. Completed claims are to be submitted to the appropriate regional District Office of Workers' Compensation Programs. Persons are not required to respond to this information collection unless it displays a currently valid OMB number.