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Survivor's Claim for 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 read the instructions on page 3 before completing this form. Provide all information requested below, and sign and date the bottom of Page 2. Do not write in the shaded areas.

OMB Control No: 1240-0002
Expiration Date: 05/31/2025

Deceased Employee Information (please print clearly)

1. Name (Last, First, Middle Initial)

2. Sex ☐ Male ☐ Female

3. Social Security Number

4. Date of Birth Month Day Year

5. Date of Death Month Day Year

6. Was an autopsy performed on the employee? ☐ YES - List Medical Facility: ☐ NO ☐ DON'T KNOW

Survivor Information (please print clearly)

7. Name (Last, First, Middle Initial)

8. Sex ☐ Male ☐ Female

9. Social Security Number

10. Date of Birth Month Day Year

11. Your relationship to the deceased employee ☐ spouse ☐ child ☐ step-child ☐ adopted child ☐ parent ☐ grandparent ☐ grandchild ☐ Other:

12. Address (Street, Apt. #, P.O. Box)

(City, State, ZIP Code)

13. Telephone Numbers

a. Home: ( ) -

b. Other: ( ) -

14. Identify the Diagnosed Condition(s) Being Claimed as Work-Related (check box and list specific diagnosis)

		15. Date of Diagnosis Month	Day	Year
☐	**Cancer** (List Specific Diagnosis Below)			
	a.			
	b.			
	c.			
	d.			
☐	**Chronic Beryllium Disease** (CBD)			
☐	**Chronic Silicosis**			
☐	**Other Work-Related Condition(s) due to exposure to toxic substances or radiation** (List Specific Diagnosis Below)			
	a.			
	b.			
	c.			
	d.			

Awards and Other Information

16. Have you or the deceased employee filed a lawsuit based on exposure to radiation, beryllium, asbestos or any other toxic substance?	☐ YES ☐ NO
17. Have you or the deceased employee filed any state workers' compensation claims in connection with any condition(s) you claim in Item 14?	☐ YES ☐ NO
18. Have you, the deceased employee, or another person received a settlement or other award in connection with a lawsuit or state workers' compensation claim described in questions 16 or 17?	☐ YES ☐ NO
19. Have you either pled guilty to or been convicted on any charges connected with an application for or receipt of federal or state workers' compensation?	☐ YES ☐ NO
20. Have you or the employee applied for an award under Section 5 of the Radiation Exposure Compensation Act (RECA)? **If yes, provide RECA Claim #:**	☐ YES ☐ NO
21. Have you or the employee applied for an award under Section 4 of RECA?	☐ YES ☐ NO

Form EE-2
September 2021

Next Page

Other Potential Survivors

22. List any person(s) who may also qualify as a survivor of the deceased employee and include the following information:

	Name	Relationship to the deceased employee	Address	Phone Number(s)
a.				Home: Other:
b.				Home: Other:
c.				Home: Other:
d.				Home: Other:
e.				Home: Other:
f.				Home: Other:
g.				Home: Other:
h.				Home: Other:
i.				Home: Other:
j.				Home: Other:

Survivor Declaration

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or 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. Any change to the information provided on this form once it is submitted must be reported immediately to the district office responsible for the administration of the claim. I hereby make a claim for benefits under EEOICPA and affirm that the information I have provided on this form is true. If applicable, I authorize the Department of Justice to release any requested information, including information related to my RECA claim, to the U.S. Department of Labor, Office of Workers' Compensation Programs (OWCP). Furthermore, I authorize any physician or hospital (or any other person, institution, corporation, or government agency, including the Social Security Administration) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs.

Claimant Signature

Date

Resource Center Date Stamp

Next Page Previous Page

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, you should explain the reason(s) for the delay and indicate when the information will be forthcoming. Submit the completed claim form and all other pertinent documentation to the following address:

U.S. Department of Labor
OWCP/DEEOIC
P.O. Box 8306
London, KY 40742-8306

Deceased Employee Information

Item 14 - Identify the employee's physician-diagnosed condition(s) that you claim are work-related. Do not list the symptoms (e.g. aches, pains, cough, wheezing, breathing problems, etc.) associated with the diagnosed condition(s). Attach to the claim form any pertinent medical documentation and copy of the employee's death certificate. If you require additional space, attach a signed supplemental statement to this form.
Item 15 - List the date a physician first diagnosed the claimed condition(s).

Awards and Other Information

Question 16 – Mark the appropriate box indicating whether you or the deceased employee filed a civil lawsuit based on exposure to any toxic substance. If you mark the box for YES, provide copies of all pertinent court documentation.
Question 17 – Mark the appropriate box indicating whether you or the deceased employee filed any state workers' compensation claims related to any condition(s) you claim in Item 14. If you mark the box for YES, provide copies of all state workers' compensation documentation.
Question 18 – Mark the appropriate box indicating whether you, the deceased employee or another person received a settlement or other award for a lawsuit or a state workers' compensation claim described in Questions 16 or 17. If you mark the box for YES, provide copies of all pertinent documentation.
Question 19 - Mark the appropriate box indicating whether or not you have ever pled guilty to or been convicted on any charges connected to an application for or receipt of federal or state workers' compensation.
Question 20 – Mark the appropriate box indicating whether you or the deceased employee filed for an award from the Department of Justice (DOJ) under Section 5 of the Radiation Exposure Compensation Act (RECA). If you mark the box for YES, provide the claim number associated with that RECA claim in the space provided.
Question 21 – Mark the appropriate box indicating whether you or the deceased employee filed for an award from DOJ under Section 4 of RECA.

Other Potential Survivors

Item 22 - Every eligible survivor of a covered employee must be identified prior to the payment of any compensation. List any individual who may also qualify as a survivor of the deceased employee and provide the additional information requested in this item, if known. Under EEOICPA, certain limitations apply to the definition of persons who may qualify as an eligible survivor. Eligible survivors of a deceased employee may include his or her: surviving spouse, child (biological, step or adopted), parent, grandchild, or grandparent. Any claim for survivor benefits must be accompanied by proof of relationship to the deceased employee. This includes, but may not be limited to, a copy of a marriage certificate, birth certificate, or adoption papers.

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 21minutes per response, including time for reviewing instructions, searching existing data sources, gathering the data needed, and completing and reviewing the collection of information. You are required to respond to this collection to obtain EEOICPA benefits (20 CFR 30.101(a)). Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, 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 both OMB Control No. 1240-0002 and Form EE-2. **Do not submit the completed form to this address.**