Claim for Consequential Illness Benefits Under the Employees Occupational Illness Compensation Program Act

U.S. Department of Labor
Office of Workers' Compensation Programs
Division of Energy Employees Occupational Illness Compensation

A consequential illness is a separately diagnosed medical condition that a physician concludes occurred or worsened because of an illness that has already been accepted as work-related under the Energy Employees Occupational Illness Compensation Program Act. **Do not use this form to claim an illness that resulted from an occupational toxic substance exposure.** Please read the instructions on page 2 before filling out this form. Provide all information requested, and sign and date the bottom of page 1.

OMB Control No. 1240-0003

Expiration Date: 07/31/2027

Employee Information (Please Print Clearly)

1. **Name** (Last, First, Middle Initial) _____

2. **Case ID Number** _____

3. **Address** (Street, Apt. #, P.O. Box) _____

(City, State, ZIP Code) _____

4. **Telephone Number(s)**

a. Home: ( ) -

b. Other: ( ) -

5. Identify the Consequential Illness(es) Being Claimed as Related to an Accepted Illness

Specific medical diagnosis only. Do not list symptoms (e.g., pains, aches, cough).	6. Date of Diagnosis Month	Day	Year
a.			
b.			
c.			
d.			
e.			

Awards and Other Information

7. Have you filed a lawsuit based on exposure to radiation, beryllium, asbestos or any other toxic substance?	☐ Yes	☒ No
8. Have you filed any state workers' compensation claims in connection with any condition(s) you claim in Item 5?	☐ Yes	☒ No
9. Have you or another person received a settlement or other award in connection with a lawsuit or state workers' compensation claim described in Questions 7 or 8?	☐ Yes	☒ No
10. Have you either pled guilty to, or been convicted of, any charges connected with an application for, or receipt of, federal or state workers' compensation?	☐ Yes	☒ No

Claimant 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. 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

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