Claim for Compensation by Widow, Widower, and/or Children

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

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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

Claim of Surviving Husband or Wife (Items 8 through 13)

8. Name and address (Include ZIP Code)	9. Your Date of Birth (Mo., day, year)	10. Date of Marriage to Employee (Mo., day, year)

11. Were you living with the employee at time of death?	12. Were you ever married to anyone other than the employee?	13. Was employee ever married to anyone other than yourself?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

14. List all of employee's children from this marriage who may be entitled to compensation (See attached information sheet for definition of children):

Name	Relationship	Date of Birth	Address (Include ZIP Code)

14a. List all of employee's children from prior marriages who may be entitled to compensation:

Name	Relationship	Date of Birth	Address (Include ZIP Code)

15. If a legal guardian has been appointed for any child named above, give name of child, name and address of the guardian.

Child	Guardian	Guardian's Address (Include ZIP Code)

16. List other relatives who were fully or partially dependent on employee:

Name	Relationship	Date of Birth	Address (Include ZIP Code)

17. If application has been made for 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. _____

18. If 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:

19. 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:

20. Total burial expense	21. Amount of burial expense paid or payable by VA	22. 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.

23. Signature of person filing claim	24. Address (Include ZIP Code)	25. Date (Mo., day, year)

Form CA-5
Rev. Jan. 1997

Attending Physician's 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 instantaneous, 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? Give the medical reasons for your opinion, unless causal relationship is obvious. ☐ Yes ☐ No

10. Was a biopsy or an autopsy performed?
If yes, give name and address of physician and arrange for a copy of the report to be submitted.
☐ Yes
☐ No

11. Name and address (Please type - include ZIP Code)	12. Signature	13. Date signed (Mo., day, year)

INSTRUCTIONS FOR COMPLETING FORM CA-5, CLAIM FOR COMPENSATION BY WIDOW, WIDOWER, AND/OR CHILDREN

Who Should File Claim	• This claim form should be completed and filed by the widow or widower for self and surviving children. If there is no surviving widow or widower, the children's guardian completes the claim.
When Should Claim Be Filed	• Claim must be filed within three years following date of death, unless the decedent's immediate superior had actual knowledge of an on-the-job injury or death within 30 days; or written notice of the injury or death was given within 30 days. The timely filing of a disability claim will satisfy the time requirements for a death claim based on the same injury.
What Documents Are Required	• The marriage certificate(s) for a widow or widower; death certificate for decedent if not previously submitted; birth certificate or adoption documents for each child. Also, if appropriate, Letter of Guardianship. If either the decedent or the surviving spouse was previously married, legal documents showing dissolution of such prior marriage(s). Copies of certificates or documents are acceptable only if they are certified by the person having official custody of such records. They should then be attached to the claim form when it is filed.
How to Complete Claim	• All items should be completed. If an item is not applicable, indicate by showing "NA". Note that the form requests information about several different categories of persons, i.e., items 1-7 make inquiry about the decedent; 8-13 the surviving widow or widower; 14-14a, surviving children; and 15, the children's guardian. The attending physician's report on the reverse of the claim must also be completed before the form is submitted to the OWCP.
Funeral/Burial Allowance	• Submit original itemized funeral and burial bills. If paid, so indicate and give name and address of person making payment. If an Administrator or Executor has been appointed, give such person's name and address and attach a copy of the appointment document.

See the reverse of this page for a definition of dependents and a description of benefits.

DEATH BENEFITS FOR SURVIVING WIDOW, WIDOWER AND/OR CHILDREN UNDER THE FEDERAL EMPLOYEES' COMPENSATION ACT (FECA)

Widow or Widower	● To qualify for benefits, a widow or widower must have been living with the employee or separated for reasonable cause prior to the time of death. Payments continue for life or until remarriage. Upon remarriage, a widow or widower will receive a lump sum equal to 24 times his or her monthly compensation. If the remarriage occurs at age 60 or later, no lump sum is paid. Instead, payments continue for life.
Children	● Eligible children include natural, adopted, step and posthumous children unmarried and under 18 years of age. Payments continue beyond 18 if the child is incapable of self-support because of mental or physical incapacity. Payments also continue on behalf of children over 18 if they are full-time students. Student benefits terminate on: marriage, completion of four years of education beyond high school level, or at age 23, whichever occurs first.
Compensation Rates	● For widows or widowers - 50% of the employee's monthly pay if there are no surviving eligible children - 45% if there are eligible children. Children - 15% each, not to exceed a total of 30%, shared equally if there is a widow or widower; if there is no widow or widower, 40% for one child plus 15% for each additional child, shared equally. Monthly payments for all beneficiaries cannot exceed 75% of the employee's monthly pay rate, or 75% of the top step of GS-15 of the General Schedule. Federal payments are made through Direct Deposit. Therefore, a completed Form SF-1199A, Direct Deposit Sign-up must be submitted with Form CA-5. If the employee was covered under the Federal Employees' Retirement System (FERS), 5 USC 8116(d)(2) requires that Social Security benefits payable to beneficiaries, which are attributable to the deceased employee's Federal Service, are deducted from the beneficiary's compensation entitlement.
Funeral/Burial Allowance	● Funeral and burial expenses up to a maximum of $800 may be paid. Amount paid by the VA will be deducted. If death occurs away from the employee's duty station, transportation costs may be paid to return the deceased employee to his home or last place of residence. In addition to any funeral or burial expenses, a sum of $200 may be paid for reimbursement of the costs of termination of the decedent's status as an employee of the United States.
Third Party Action	● If the injury or death results from activity of a person or party other than the Federal Government, a "third party action" or lawsuit may be indicated. In such instances the Department of Labor will provide further instructions.

If additional information is needed, it may be obtained from the Office of Workers' Compensation Programs.

Privacy Act Notice

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) 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 FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency 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 issues relating to retention, rehire, or other relevant matters. (4) Information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection Act. (7) Disclosure of the claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/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. (8) 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 or reduced level of benefits.

Note: 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 FECA.

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 90 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, 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.

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

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