<u>COMPENSATION PAYMENTS</u>

Total disability benefits may be paid to injured workers to compensate them for **lost wages** after the end of a continuation-of-pay period or from the beginning of pay loss. An employee who receives disability payments will be notified by letter of the amount of compensation to be paid, including the pay rate used as a basis and the resulting compensation rate. Compensation payments for total disability may continue as long as the medical evidence substantiates total disability.

No compensation is payable for the first three days of wage loss unless the disability exceeds 14 days after the expiration of COP, where COP is payable, or the injury results in permanent impairment. Injured employees may use sick or annual leave credited to their account if so desired, in which event FECA compensation does not begin until the expiration of leave. Use of personal leave should only be necessary in extreme circumstances.

Monetary compensation is based on the monthly pay of the injured employee at the time of the injury, at the time the disability begins, or at the time a compensable disability recurs (if such recurrence begins more than six months after the injured employee resumes regular full-time employment with the United States), whichever is greater.

FECA compensation generally is calculated at two-thirds of the employee's monthly pay rate if he or she has no dependents, or three-fourths of the pay rate if married or with one or more dependents.

For FECA benefit purposes, a dependent is: a wife or husband residing with the employee or receiving regular support payments from him or her; an unmarried child who lives with the employee or who receives regular support payments from him or her who is under age 18, or if over age 18 is incapable of self-support due to physical or mental disability; a student between 18 and 23 years of age who has not completed four years of post-high school education and who is regularly pursuing a full-time course of study; and a parent who is wholly dependent on the employee. Locality, night differential, hazard, premium, holiday, and Sunday pay are included in determining the pay rate on which compensation is based, although overtime pay is not.

Schedule awards are FECA payments that are provided for specified periods of time for the permanent loss, or loss of use, of certain parts and functions of the body. Partial loss or loss of use of these parts and functions is compensated on a proportional basis. Before payment of a schedule award can be considered, the condition of the affected part of the body must reach maximum improvement. This determination involves a medical judgment that the condition has permanently stabilized.

Should a claimant pay for any **medical expenses, reimbursement** can be obtained by completing Form CA-915, Claimant Medical Reimbursement Form, and submitting a copy with each Form HCFA-1500, OWCP-1500, or Universal Claim Form. Claims for hospital charges must be submitted on Form UB-92. OWCP will accept signed

statements by providers, a mechanical stamp showing receipt of payment, photocopies of canceled checks (both front and back), or a copy of a credit card receipt.

Coverage also extends to the necessary cost of **transportation and expenses** incident to securing medical services, appliances and supplies. An employee can be reimbursed for reasonable transportation expenses incurred while obtaining medical treatment. A distance of 25 miles from the employee's home or the employing agency is usually considered a reasonable distance within which to travel. Travel should be undertaken by the shortest route and by public conveyance such as bus or subway unless the employee's medical condition requires the use of a taxicab or specially equipped vehicle. If an automobile is used, the employee will be reimbursed at the standard mileage rate for government travel. OWCP Form 957 should be used to claim reimbursement for travel expenses.

If an employee uses sick or annual leave due to an on-the-job injury, there is a method by which the leave can be restored and compensation paid instead. Such leave may be repurchased, subject to agency concurrence, if the claim is approved and medical evidence shows the employee was unable to work because of the injury during the period claimed. An employee who chooses to use sick or annual leave may request **"leave buy back"** by submitting Form CA-7 to OWCP through the employing agency. Any compensation payment is to be used to partially reimburse the agency for the leave pay. The employee must also arrange to pay the agency the difference between the leave pay based on 100 percent of the employee's usual wage rate and the compensation payment which is paid at two-thirds or three-fourths of the wage rate. The agency will then restore the leave to the employee's leave record.

WAGE LOSS

If disability is anticipated at the time of injury, the employee may elect to use leave or COP on Form CA-1. An employee who cannot return to work when COP terminates, or who is not entitled to receive COP, may claim compensation for wage loss on Form CA-7. In controverted cases where pay is terminated, Form CA-7 should be submitted with Form CA-1.

When to File - If disability is expected to continue beyond the period of entitlement to COP, the employee may claim compensation or use leave to cover his or her absence from work. If it is not clear whether the employee will remain disabled after the 45 days of COP are used, claim for compensation should be initiated. Employees who have filed claims should be carried in LWOP status. If an employee returns to work after Form CA-7 has been filed, however, the supervisor should notify DHRC-I by telephone to avoid overpayments, and later provide written confirmation of return to duty.

If compensation is to be claimed, the supervisor should give Form CA-7 to the employee on the 30th day of COP with instructions to complete the front and return the form to the agency within one week. (If the employee has not returned it by the 40th day of COP, the supervisor should contact him or her by telephone and request that it be submitted as soon as possible).

When the form is returned, the supervisor should complete the reverse of the form, including the name and the telephone number of an agency official with direct knowledge of the claim. The employee should arrange to provide medical evidence to support the period of disability claimed; this evidence may be submitted with the Form CA-7 or sent to separately.

After completing the form, the supervisor should submit it to DHRC-I along with any new medical evidence in the agency's possession. OWCP will use the pay data supplied by agency personnel to determine the rate at which compensation is to be paid. (Submission should not be delayed for computation of shift differential, Sunday or holiday pay, or other incremental pay). The dates of compensation claimed should represent the period of disability supported by the medical evidence or the interval until the employee's next medical appointment.

SCHEDULE AWARD

Compensation is provided for specified periods of time for the permanent loss, or loss of use, of certain parts and functions of the body. Partial loss or loss of use of these parts and functions is compensated on a proportional basis. Following is a table which shows the number of weeks payable for each schedule member if the loss or loss of use of the function or part of the body is total:

Member. . . . . Weeks

Arm 312

Leg 288

Hand 244

Foot 205

Eye 160

Thumb 75

First finger 46

Great toe 38

Second finger 30

Third finger 25

Toe other than great toe 16

Fourth finger 15

Loss of hearing--monaural 52

binaural. 200

Breast 52

Kidney 156

Larynx 160

Lung 156

Penis 205

Testicle 52

Tongue 160

Ovary (including

Fallopian tube) 52

Uterus/cervix. 205

Vulva/vagina. 205

Compensation for loss of binocular vision or for loss of 80 percent or more of the vision of an eye is the same as for loss of the eye. The degree of loss of vision or hearing for a schedule award is determined without regard to correction; that is, improvements obtainable with use of eyeglasses and hearing aids are not considered in establishing the percentage of impairment. The law contains no provision for payment of a schedule award on account of permanent impairment to the back, heart or brain.

Before payment of a schedule award can be considered, the condition of the affected part of the body must reach maximum improvement. This determination involves a medical judgment that the condition has permanently stabilized. In most cases the percentage of impairment is determined in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, and the evaluation on which the award is based must conform to the guidelines set forth in that publication.

If a claim for wage loss has not previously been submitted, Form CA-7 may be used to initiate a claim for schedule award. Otherwise, consideration may be requested by narrative letter. Compensation for schedule awards is computed by multiplying the indicated number of weeks times 66 2/3 percent (without dependents) or 75 percent (with dependents) of the pay rate (see paragraph (1) above for more information concerning dependents).

When a schedule award is issued, the employee and agency will be notified of the length of the award (in number of weeks or days), the starting date of the award (the date of maximum medical improvement), the pay rate on which benefits are computed, and the compensation rate. The decision will include a description of the employee's appeal rights should he or she disagree with any element of the decision.

Schedule awards can be paid even if the employee returns to work. Employees may not, however, receive wage loss compensation and schedule awards benefits concurrently for the same injury. If an employee sustains a period of temporary total disability during the course of the award, it may be interrupted to pay the period of disability; the schedule award will resume afterwards. If an employee dies during the course of a schedule award from causes unrelated to the compensable injury, his or her dependents are entitled to the balance of the award at the rate of 66 2/3 percent.

REIMBURSEMENT

An employee may request reimbursement by completing Form CA-915 (also referred to as Form OWCP-915) and submitting receipted bills from the provider. Hospital bills must be stamped "paid" or otherwise certified to show that payment was made. Cash sales receipts that bear imprints of mechanical cash registers may be accepted if the nature of the sale is identified. Photocopies of cancelled checks may be accepted in lieu of receipts but must be accompanied by itemized bills or other evidence of the charge for which payment was made. Prescription receipts must include the name of the drug and the date the prescription was filled. As with direct bill payments to providers by OWCP, the amount claimed may be reduced according to the OWCP fee schedule of allowable charges.

TRANSPORTATION EXPENSE

When transportation to obtain medical care is not furnished by the government, the employee may be reimbursed for travel expenses. Travel should be undertaken by the shortest route and by public conveyance such as bus or subway unless the employee's medical condition requires the use of a taxicab or specially equipped vehicle. An employee who uses his or her automobile will be reimbursed at the standard mileage rate for government travel.

OWCP 957 should be used to claim reimbursement for travel expenses. All items will be reimbursed on the basis of actual expense; a per diem allowance is not payable. Wages and travel expenses of an attendant to accompany the employee may be approved if his or her condition is such that travel cannot be accomplished otherwise. Authorization for this expense should be obtained in advance of the travel if possible.

LEAVE BUY-BACK

If an injured Federal employee elects to use sick or annual leave during a period of disability, the employee may (with agency approval) claim compensation for the period of disability and "buy back" the leave used. Compensation for leave repurchase is computed in the same way as compensation for temporary total disability. Since leave is paid at 100 percent of the usual wage rate, while compensation is paid at either 66 2/3 percent of 75 percent of the employee's usual pay rate, the employee must refund to the agency the difference between the compensation entitlement and the total amount of leave paid by the agency. Buy back of leave is subject to agency concurrence and availability of official leave records (any sick leave or annual leave used during the 45 day Continuation of Pay (COP) period cannot be used for leave-buy-back purposes unless the employee was not entitled to COP).

Before leave-buy-back procedures begin, the following criteria must be met:

1. OWCP has approved the employee's claim for compensation benefits.

2. The employee used sick or annual leave due to the disability.

3. The claim for leave buy-back is submitted within one year of the date the leave was used or the claim was accepted, whichever is later. (This would assure leave records and medical documentation are available to support disability for the period claimed.)

4. Requests for leave buy-back shall be submitted for a minimum of ten hours of leave unless no further claims are anticipated. Medical documentation must be provided for all dates claimed.

To initiate a claim for leave buy-back, the injured employee and his or her supervisor should complete Form CA-7. Form CA-7a is used when dates of leave are intermittent or when more than one continuous period of leave is claimed. The completed Form CA-7 (and CA-7a were applicable) should be forwarded to DHRC-I along with supporting medical documentation.

DHRC-I will compute an estimate of the employee's OWCP compensation entitlement amount on Form CA-7b. The Defense Finance and Accounting Service (DFAS) will provide the actual monetary (salary) amount received by the employee during the period in which the leave was used. This amount will also be annotated on Form CA-7b. The employee will be responsible for repaying to the Agency the difference between the actual salary he or she received, and the compensation entitlement amount.

After receiving the cost estimate, the employee will decide whether he or she wishes to proceed with the leave buy-back. If the employee elects to proceed, DHRC-I submits the completed Forms CA-7, CA-7a, and CA-7b to OWCP. OWCP will compute the employee's actual compensation entitlement and they will issue a payment to DFAS.

Once DFAS receives OWCP's payment, they will determine the final amount owed by the employee.

Employees have the option of repaying the final amount in a lump sum via personal check to DFAS, or they may elect to repay the final amount via payroll deduction. Leave is restored after DFAS receives the full amount payable from the employee.

Impact on Leave Forfeiture and Leave Earnings - The employee's leave record for the buyback period must be changed to leave-without-pay (LWOP) in order for compensation to be paid. Since leave is not earned during a period when an employee is in a LWOP status, the repurchase for leave may result in a reduction of earned leave. In addition, the employee will no longer be entitled to pay received for any holiday that was included within the period of LWOP. If annual leave is to be re-credited to the employee's account and it exceeds the maximum permissible carryover balance, the excess amount is subject to forfeiture.

Tax considerations – because compensation benefits paid by OWCP are tax-free, leave buyback may impact the employee's annual income tax return filing requirements. Employees are encouraged to contact the Internal Revenue Service for specific advice and assistance.

LUMP SUM PAYMENTS

The Federal Employees' Compensation Act was designed to provide periodic payments of compensation benefits so that beneficiaries would have a continuing source of income. With few exceptions, such benefits are free from speculation, fluctuation, and attachment by creditors, and they are also generally free from taxes. OWCP will consider making a lump-sum payment of compensation only to pay a schedule award or as a survivor's benefit to a widow or widower who remarries before age 55.

RECORDING EMPLOYEE ABSENCES DUE TO WORK-RELATED INJURIES AND DISEASE

FOR TRAUMATIC INJURIES:

Traumatic injuries are reported on the form CA-1, Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation. Injured employees may elect to use their own sick or annual leave, or continuation of pay (COP) for any work absences. If the employee elects COP, code "LU" should be used to record the employee's absence on the date of injury. Only the actual number of hours missed from work should be recorded under this code. If no time is lost on date of injury, the time included under the “LU” code should be input using a fraction of time (i.e., 0.25 hrs) to account for the administrative time spent completing injury-related paperwork. At no time should the code "LU" ever be used beyond the date of injury. For time-loss on days subsequent to the date of injury subsequent days, code "LT" should be used. Once again, only the actual number of hours missed from work should be recorded under this code. Please remember that COP is a limited entitlement, and that all absences charged to "LU" or "LT" must be supported by medical documentation. For time-loss from work beyond the COP entitlement period, the employee's absence should be recorded as sick or annual leave, or leave without pay (LWOP) in accordance with the employee's request. Should the employee elect LWOP, code "KD" should be used. All absences must be supported by medical documentation.

FOR OCCUPATIONAL ILLNESSES AND DISEASES:

Occupational illnesses and diseases are reported on the form CA-2, Notice of Occupational Disease and Claim for Compensation. Injured employees may elect to use their own sick or annual leave, or claim LWOP for any work absences. If the employee elects LWOP, code "KD" should be used. At no time should the COP codes of "LU" and "LT" ever be used for absences from work related to occupational illnesses or diseases. All absences must be supported by medical documentation.

DEATH BENEFITS

When an employee dies because of an injury incurred while in performance of duty, the supervisor should immediately notify the DHRC-I by telephone or facsimile message. The supervisor should also contact any survivors, provide them with claim forms, and assist them in preparing the claim as much as possible. The forms should be submitted even if a disability claim had previously been filed and benefits were paid. Continuation of benefits is not automatic, as it must be shown that the death resulted from the same condition for which the disability claim was accepted.

The survivors of a deceased employee should use Form CA-5 or CA-5b to submit claims for death benefits. The survivor should complete the front of the appropriate form, while the attending physician should complete the medical report on the reverse and forward it to the DHRC-I for processing. The submission should include a copy of the death certificate which has been certified by the issuing authority. It should also include a certified marriage certificate if a spouse is making claim, and a copy of any divorce or annulment decree if the decedent or spouse was formerly married. The submission should include certified copies of birth certificates of any children for whom claim is made.

The supervisor completes and submits form CA-6 to the DHRC-I to report the work-related death of an employee.

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

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

OMB No. 1215-0155
Expires: 04-30-2001

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.

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402

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

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

OMB No. 1215-0155
Expires: 04-30-2004

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
Smith Larry P	05/04/1940	04/30/2004	04/30/2004	123-55-5555

6. Name and address of employing agency (Include ZIP Code)	7. Nature of injury which caused death
Defense Logistics Agency -J1 ICC Ft. Belvoir VA 22060	Car Accident

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)
Peggy Smith 2345 James Ct Philadelphia PA 12345	03/02/1942	06/01/1963

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?
[x] Yes [ ] No	[ ] Yes [x] No	[ ] Yes [x] 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)
None			

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 [x] CSRS [ ] FERS [ ] SSA [ ] Other

Claim Number for each claim: a. CSA123456 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: N/A 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:
$ 10500.00	$	$

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)
	2345 James Ct. Philadephia PA 12345	

Form CA-5
Rev. Jan. 1997

SAMPLE

Attending Physician's Report

1. Name of deceased employee (Last, first, middle)	2. Date of death (Mo., day, year)
Smith Larry P	04/30/2004

3. What history of injury or employment related disease was given to you?	4. If treated for disease, give diagnosis.
Employee involved in motor vehicle accident while TDY.	

5. If death was not instantaneous, describe the treatment you provided.	6. Show dates on which treatment was given.
	04/30/2004

7. What was the direct cause of death?

Head Trauma

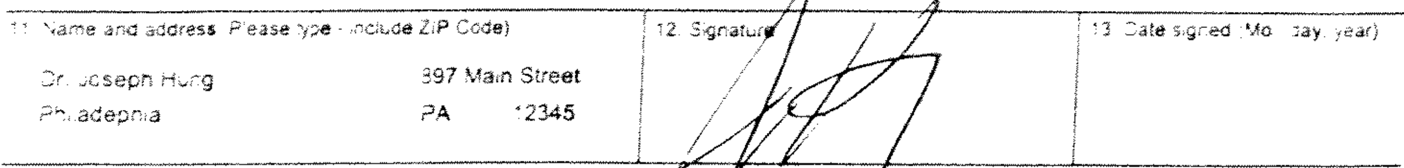
8. What were the contributory causes of death, if any?

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? [•] Yes [ ] No

If yes, give name and address of physician and arrange for a copy of the report to be submitted.

Dr. David York 897 Main Street
Philadephia PA 12345



11. Name and address (Please type - include ZIP Code)	12. Signature	13. Date signed (Mo., day, year)
Dr. Joseph Hung 897 Main Street Philadepnia PA 12345		

Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren

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

OMB No. 1215-0155
Expires: 04-30-98

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

8. Name of dependent (Last, first, middle)	9. Dependent's address (Include ZIP Code)	10. Dependent's birth date (Mo., day, year)

11. Dependent's Occupation	12. Dependent's Social Security Number	13. Dependent's relationship to employee	14. Extent of dependency on employee ☐ Total ☐ Partial

15. Total amount employee contributed to dependent's support during 12 months immediately prior to death.	16. Did employee live with dependent during the 12 months immediately prior to death?	17. Total amount employee paid dependent in money or service for room and board in addition to amount shown in 15.	18. If no fixed amount was paid for room and board, what is the fair value of such room and board?
$	☐ Yes ☐ No If "Yes", Complete 17 & 18.	$ Per	$ Per

19. If dependent was employed during 12 month period prior to employee's death, give:	20. Show dependent's income from all sources other than employment during 12 month period prior to employee's death:
Type of work performed:	Investments $
Period of employment:	Pensions
Monthly pay rate:	Persons other than employee
Name and address of employer:	Other
	Total $

Information about dependent's husband or wife (Items 21 through 25)

21. Birth Date (Mo., day, year)	22. Occupation	23. Monthly pay rate	24. Total income from all sources for 12 months prior to employee's death.
		$	$

25. List all property owned by dependent and husband or wife (omit clothing, furniture, personal items).

Description	Date Acquired	Value

26. If an application has been made for U.S. Civil Service Annuity or any other Federal Retirement or Disability Law because of employee's death, give:	27. If an application has been made for Veterans Administration (VA) benefits because of employee's death, give:
Retirement System: ☐ CSRS ☐ FERS ☐ SSA ___ Other	Service number: VA Claim number:
Claim number for each claim: a. ___ b. ___	Address of VA office where claim is filed:
Date each benefit began: a. ___ b. ___	28. If a claim has been made against a third party because of employee's death, give:
Amount of each benefit paid per month: $ a. ___ b. ___	Amount of recovery: $ Name and address of third party:

29. Total burial expense	30. Amount of burial expense paid or payable by VA	31. 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. Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both.

32. Signature of person filing claim	33. Address (Include ZIP Code)	34. Date (Mo., day, year)

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? Arrange for a copy of the report to be submitted. ☐ Yes ☐ No

11. Name and address (Please type - include ZIP Code)

I certify that all statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any knowingly false or misleading statement or concealment of material fact may subject me to felony criminal prosecution.

12. Signature

13. Date signed (Mo., day, year)

DEATH BENEFITS FOR PARENTS, BROTHERS, SISTERS, GRANDPARENTS AND GRANDCHILDREN UNDER THE FEDERAL EMPLOYEES' COMPENSATION ACT (FECA)

Eligible Dependents
- Benefits are payable on behalf of partially or totally dependent parents, brothers, sisters, grandparents and grandchildren.

Period Of Entitlement
- Parents and grandparents: Payments continue until death, remarriage or termination of dependency.

  Minor brothers, sisters and grandchildren: Payments continue until death, marriage or attainment of 18 years of age. Payments may continue beyond 18 if the child is mentally or physically incapable of self-support or is a "full-time" student. Student benefits terminate on: marriage, completion of 4 years of education beyond high school level, or at age 23, whichever occurs first.

Compensation Rates
- For parent - 25% of the employee's monthly pay, if one is wholly dependent and the other is not dependent at all. If both are wholly dependent - 20% each. A proportionate amount is paid if either or both are partially dependent.

  Brothers, sisters, grandparents, and grandchildren - 20% if only one is wholly dependent. If more than one is wholly dependent - 30% shared equally. If one or more is partially dependent - 10% shared equally if more than one.

  Federal payments are made through Direct Deposit. Therefore a completed Form SF-1199A, Direct Deposit Sign-up must be submitted with Form CA-5b.

  If the employee was covered under the Federal Employees's Retirement System (FERS), 5 USC 811(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.

Payment Priorities
- Monthly payments for all beneficiaries cannot exceed 75% of the employee's monthly salary or 75% of the top step of GS-15 of the General Schedule. The surviving widow or widower and children have first priority. Other eligible dependents may receive payment only if the widow or widower and children's percentages are less than 75%.

Funeral/Burial Allowance
- Funeral and burial expense 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 employee's death was caused by 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.

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.

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

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.

☆U.S. GPO:1998-433-244/72703

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INSTRUCTIONS FOR COMPLETING FORM CA-5b, CLAIM FOR COMPENSATION BY PARENTS, BROTHERS, SISTERS, GRANDPARENTS OR GRANDCHILDREN

Who Should File Claim	This claim form should be completed and filed by the deceased employee's parents, grandparents or representative (custodian or guardian) of minor brothers, sisters or grandchildren. A separate form is required for each person claiming benefits.
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 birth certificate of the deceased employee; also a death certificate if not previously submitted; birth certificates for minor brothers, sisters and grandchildren. If claim is made on behalf of a grandparent, birth certificate of decedent's mother or father, as appropriate. If claim is made on behalf of a grandchild, birth certificate of decedent's son or daughter as appropriate. 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 on the claim form should be completed. If an item is not applicable, indicate by showing "NA". Note that the claim form requests information about several categories of persons, i.e., items 1-7 make inquiry about the decedent; 8-20 the dependent; 21-25 the dependent's husband or wife, if married at the time of employee's death. The attending physician's report on the reverse of the form 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.

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 Worker's 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

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Official Superior's Report of Employee's Death

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

1. Name of Deceased Employee (Last, first, middle)

2. Date of Birth (Mo., day, year)

3. ☐ Male ☐ Female

4. Social Security No.

5. Department or Agency

6. OWCP Agency Code

7. OSHA Site Code

8. Name and Address of Reporting Office

9. Name and Office Phone Number of Employee's Official Superior

10. Date and Hour of Injury (Mo., day, year) ☐ AM ☐ PM

11. Date and Hour of Death (Mo., day, year) ☐ AM ☐ PM

12. Date and Hour Employee's Pay Stopped (Mo., day, year) ☐ AM ☐ PM

13. Describe how injury occurred

14. Was employee in performance of duty when injury occurred? ☐ Yes ☐ No (If No, explain):

15. Location where injury occurred

16. Location where death occurred

17. Immediate cause of death (Attach medical and autopsy report if available)

18. Employee's pay rate as of	a. Base pay	b. Subsistence	c. Quarters	d. Other
A. Date of injury	$ per	$ per	$ per	$ per
B. Date pay stopped	$ per	$ per	$ per	$ per

19. Did employee work in position held at time of injury for a full eleven months immediately prior to the injury? ☐ Yes ☐ No

20. If answer to 19 is no, would position have afforded employment for eleven months except for the injury? ☐ Yes ☐ No

21. Did employee receive leave pay for any part of period from time pay stopped to date of death? (Give inclusive dates)
From To

22. a. Occupation code
b. Type code
c. Source code
OWCP use - NOI code

23. Did employee receive continuation of pay (COP) during period prior to death?
a. Pay rate used for COP
$ per
b. Inclusive dates of COP
From To

24. If employee was enrolled in Health Benefit Plan for self and family, show HBS Code Number:

25. Show date through which HBS deductions were last made (Mo., day, year)

26. If employee received medical care prior to death, give name and address of attending physician

27. If injury was caused by a third party, give name and address of third party

28. Give name and address of the attorney representing the survivors if legal action is instituted against the third party

29. Show amount of third party recovery, if any
$

30. If employee was a member of the Armed Services of the United States, show:
Branch of Service:
Serial No. (If known)

31. Has claim for survivor's benefits been filed with the Office of Personnel Management? ☐ Yes ☐ No

32. Name and address of employee's spouse or next of kin (Show relationship, if other than spouse)

33. Signature of Official Superior

34. Title

35. Date (Mo., day, year)

Form CA-6

Instructions for Completing Form CA-6

When a Federal employee dies as a result of injury in performance of duty or because of an employment related disease, the death should be reported on this form. This form eliminates the need to complete and file the official superior's report on Form CA-1, Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation or Form CA-2, Federal Employee's Notice of Occupational Disease and Claim for Compensation.

The form is to be completed by the deceased employee's official superior or other authorized official of the employing agency. It should be accompanied by a certified copy of the death certificate, when submitted to OWCP.

Form CA-5 or CA-5b should be supplied to the employee's spouse or next of kin.

If additional space is required, attach separate sheets and number the answers to correspond with the items on the form.

For additional information about death benefits, see 20 CFR 1.1 and/or Chapter 810, Injury Compensation, Federal Personnel Manual.

Box 22a (Occupation Code), Box 22b (Type Code), Box 22c (Source Code), OSHA Site Code

The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, Recordkeeping and Reporting Guidelines.

OWCP Agency Code

This is a four digit (or four digit plus two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

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Official Superior's Report of Employee's Death

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

SAMPLE

1. Name of Deceased Employee (Last, first, middle): GOODE, Jason B.
2. Date of Birth (Mo., day, year): 6/02/57
3. ☑ Male ☐ Female
4. Social Security No.: 000-11-2345
5. Department or Agency: US Army Materiel Command Red River Army Depot
6. OWCP Agency Code: 1234AB
7. OSHA Site Code:
8. Name and Address of Reporting Office:
   SDSRR-RM
   Red River Army Depot
   Texarkana, TX 75507
9. Name and Office Phone Number of Employee's Official Superior: Jim Morris (222) 345-6789
10. Date and Hour of Injury (Mo., day, year): ☑ AM ☐ PM
11. Date and Hour of Death (Mo., day, year): 2/1/95 0730 ☐ AM ☑ PM
12. Date and Hour Employee's Pay Stopped (Mo., day, year): 2/1/95 0400 ☐ AM ☑ PM
13. Describe how injury occurred: Employee lost control of government vehicle when tire blew.
14. Was employee in performance of duty when injury occurred? ☑ Yes ☐ No (If No, explain):
15. Location where injury occurred: Eastern Drive
16. Location where death occurred: Memorial Hospital
17. Immediate cause of death (Attach medical and autopsy report if available): Massive head trauma
18. Employee's pay rate as of

	a. Base pay	b. Subsistence	c. Quarters	d. Other
A. Date of injury 1/27/95	$ 14.64 per hr.	$ N/A per	$ N/A per	$ N/A per
B. Date pay stopped 2/1/95	$ 14.64 per	$ per	$ per	$ per

19. Did employee work in position held at time of injury for a full eleven months immediately prior to the injury? ☑ Yes ☐ No
20. If answer to 19 is no, would position have afforded employment for eleven months except for the injury? ☐ Yes ☐ No
21. Did employee receive leave pay for any part of period from time pay stopped to date of death? (Give inclusive dates) From To N/A
22. a. Occupation code: 0801
    b. Type code: 800
    c. Source code: 0421
    OWCP use - NOI code:
23. Did employee receive continuation of pay (COP) during period prior to death?
    a. Pay rate used for COP: $ 14.64 per hour
    b. Inclusive dates of COP: From 1/28/95 To 2/1/95
24. If employee was enrolled in Health Benefit Plan for self and family, show HBS Code Number: 202
25. Show date through which HBS deductions were last made (Mo., day, year): 1/29/95
26. If employee received medical care prior to death, give name and address of attending physician: Larry Smith, MD Memorial Hospital
27. If injury was caused by a third party, give name and address of third party: N/A
28. Give name and address of the attorney representing the survivors if legal action is instituted against the third party: N/A
29. Show amount of third party recovery, if any: $ N/A
30. If employee was a member of the Armed Services of the United States, show:
    Branch of Service: Navy
    Serial No. (if known): 444-66-7788
31. Has claim for survivor's benefits been filed with the Office of Personnel Management? ☑ Yes ☐ No
32. Name and address of employee's spouse or next of kin (Show relationship, if other than spouse):
    Mary I. Goode
    100 Birch Field Drive
    Texarkana, TX 75506
33. Signature of Official Superior:
34. Title: Chief, Systems Branch
35. Date (Mo., day, year): 2/7/95

PUBLIC LAW 109_234 SUPPLEMENTAL DEATH BENEFITS

Public Law 109-234, the Defense Supplemental Appropriations Act, was signed by the President on June 15, 2006. One provision of that law provides an additional death benefit to certain civilian employees of the Department of Defense that you should know about, so that you can properly counsel other DoD personnel on the level of benefits payable in case of job-related death.

Section 413 of the Foreign Service Act of 1980, codified in Section 3973 of Title 22 of the U.S. code, provided for the payment of an amount equal to one year of the employee's salary at the time of death to certain members of the Foreign Service who died outside the United States in the performance of duty. Public Law 109-234 extended this benefit to civilian employees of the Department of Defense who died in the performance of duty in Iraq and Afghanistan, whether on Temporary Duty or Temporary
or Permanent Change of Station. The law was not retroactive, meaning that individuals who died before June 15, 2006 are not eligible for this benefit. The text of this legislation is noted on page 2 of this document.

Benefits under this provision are payable in addition to any benefits payable under the Federal Employees' Compensation Act (FECA). These benefits may also be paid at the same time as the $10,000 death gratuity that is payable under Section 651 of Public Law 104-208. However, this payment cannot be made until the Department of Labor, Office of Workers' Compensation Programs determines that a survivor is entitled to elect death benefits under FECA. Benefits are payable first to the widow or widower, then to a child or children on a share-and-share alike basis, then to dependent parents; if none of these classes of beneficiaries is alive, no benefits under this provision are payable. Payments will be made by DoD for this benefit, not the Department of Labor, probably in a manner similar to the way that a $10,000 death gratuity is currently paid; we will get you more details about the mechanism for payment as more detailed procedures are written and approved. The enabling legislation specifies [in Section 1603(c)] that the money received under Public Law 109-234 is non-taxable. The legislation also states that the authority for this payment expires at the end of Fiscal Year 2008, so payments under this
law must be made prior to October 1, 2008.

PUBLIC LAW 109–234—JUNE 15, 2006 120 STAT. 443
SEC. 1603. (a) IN GENERAL.—During fiscal years 2006, 2007, and 2008, the head of an agency may, in the agency head's discretion, provide to an individual employed by, or assigned or detailed to, such agency allowances, benefits, and gratuities comparable to those provided by the Secretary of State to members of the Foreign Service under section 413 and chapter 9 of title I of the Foreign Service Act of 1980 (22 U.S.C. 3973; 4081 et seq.), if such individual is on official duty in Iraq or Afghanistan.

(b) CONSTRUCTION.—Nothing in this section shall be construed to impair or otherwise affect the authority of the head of an agency under any other provision of law.

(c) APPLICABILITY OF CERTAIN AUTHORITIES.—Section 912(a) of the Internal Revenue Code of 1986 shall apply with respect to amounts received as allowances or otherwise under this section in the same manner as section 912 of the Internal Revenue Code of 1986 applies with respect to amounts received by members of the Foreign
Service as allowances or otherwise under chapter 9 of title I of the Foreign Service Act of 1980.