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)

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? ☐ Yes ☐ No
Give the medical reasons for your opinion, unless causal relationship is obvious.

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.

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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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)
Defense Logistics Agency -J1 ICC
Ft. Belvoir VA 22060

7. Nature of injury which caused death
Car Accident

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

8. Name and address (Include ZIP Code)
Peggy Smith 2345 James Ct
Philadelphia PA 12345

9. Your Date of Birth (Mo., day, year)
03/02/1942

10. Date of Marriage to Employee (Mo., day, year)
06/01/1963

11. Were you living with the employee at time of death? [•] Yes [ ] No

12. Were you ever married to anyone other than the employee? [ ] Yes [•] No

13. Was employee ever married to anyone other than yourself? [ ] 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)
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 [•] 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 $ 10500.00

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)
2345 James Ct.
Philadelphia PA 12345

25. Date (Mo., day, year)

Form CA-5
Rev. Jan.1997

Attending Physician's Report

1. Name of deceased employee (Last, first, middle)
Smith Larry P

2. Date of death (Mo., day, year)
04/30/2004

3. What history of injury or employment related disease was given to you?
Employee involved in motor vehicle accident while TDY.

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.
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?
If yes, give name and address of physician and arrange for a copy of the report to be submitted.
[•] Yes
[ ] No

Dr. David York 897 Main Street
Philadephia PA 12345

11. Name and address (Please type - include ZIP Code)
Dr. Joseph Hung 897 Main Street
Philadephia PA 12345

12. Signature

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

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? Yes No
Give the medical reasons for your opinion, unless causal relationship is obvious.

10. Was a biopsy or an autopsy performed? ☐ Yes ☐ No
Arrange for a copy of the report to be submitted.

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.

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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

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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
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
OWCP use - NOI code
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

1. Name of Deceased Employee (Last, first, middle)	2. Date of Birth (Mo., day, year)	3.	4. Social Security No.
GOODE, Jason B.	6/02/57	☑ Male ☐ Female	000-11-2345

5. Department or Agency	6. OWCP Agency Code	7. OSHA Site Code
US Army Materiel Command Red River Army Depot	1234AB	

8. Name and Address of Reporting Office	9. Name and Office Phone Number of Employee's Official Superior
SDSRR-RM Red River Army Depot Texarkana, TX 75507	Jim Morris (222) 345-6789

10. Date and Hour of Injury (Mo., day, year)	11. Date and Hour of Death (Mo., day, year)	12. Date and Hour Employee's Pay Stopped (Mo., day, year)
☑ AM ☐ PM	2/1/95 0730 ☐ AM ☑ PM	2/1/95 0400 ☐ AM ☑ PM

13. Describe how injury occurred	14. Was employee in performance of duty when injury occurred?
Employee lost control of government vehicle when tire blew.	☑ 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)
Eastern Drive	Memorial Hospital	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?	20. If answer to 19 is no, would position have afforded employment for eleven months except for the injury?
☑ Yes ☐ No	☐ Yes ☐ No

21. Did employee receive leave pay for any part of period from time pay stopped to date of death? (Give inclusive dates)	22. a. Occupation code
From To N/A	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	b. Inclusive dates of COP
$ 14.64 per hour	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:	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
202	1/29/95	Larry Smith, MD Memorial Hospital

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
N/A	N/A	$ N/A

30. If employee was a member of the Armed Services of the United States, show:	31. Has claim for survivor's benefits been filed with the Office of Personnel Management?
Branch of Service: Navy Serial No. (if known) 444-66-7788	☑ 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	35. Date (Mo., day, year)
	Chief, Systems Branch	2/7/95

Form CA-6

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.