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

U.S. Department of Labor
Office of Workers' Compensation Programs

OMB No. 1240-0013
Expires: 07-31-2013

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:
- Type of work performed:
- Period of employment:
- Monthly pay rate:
- Name and address of employer:

20. Show dependent's income from all sources other than employment during 12 month period prior to employee's death:

Investments	$
Pensions	
Persons other than employee	
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:

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.

27. If an 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:

28. 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:

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 9 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)

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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 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 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/adminsitrative offset and debt collection actions required or permiotted by the FECA and/or the Debt Collection Act. (7) Disclosure of the claimaint'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 govoenrment, and for other purposes required or authorized by law. (8) Failure to disclose all requested ifnormation 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. The obligation to respond to this collection is required to obtain or retain a benefit (5 U.S.C. 8101 et seq.). 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, and reference the OMB Control Number 1240-0013.

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.

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