U.S. DEPARTMENT OF LABOR
Employment Standard Administration
Office o Worke-r Comp-n-otion Program

CLAIM FOR COMPENSATION BY WIDOW, WIDOWER, AND/OR CHILDREN

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
DOE, JOHN HENRY	6/14/32	9/15/82	9/15/82	000-00-0000

6. NAME AND ADDRESS OF EMPLOYING AGENCY (Include- Zlp Code
Peace Corps, 806 Connecticut Ave.
N.W. Washington D.C. 20003

7 NATURE OF INJURY WHICH CAUSED DEATH
Fractured Skull

CLAIM OF SURVIVING HUSBAND OF WIFE (Item 8 through 13)

8. Name AND ADDRESS (Include- Zip Code)
ALICE J Doe
111-15th. Street, SE
Washnington D.C. 20003

9. YOUR DATE OF BIRTH (Mo., day, year) 3/19/35

10. DATE OF MAR-RIAGE TO EMPLOYEE (Mo., day, year) 8/05/56

11. WERE YOU LIVING WITH THE EMPLOYEE AT TIME OF DEATH? ☐ YES ☐ NO

12. WERE YOU EVER MARRIED TO ANY-ONE OTHER THAN THE EMPLOYEE? ☐ YES ☒ NO

13. HAS EMPLOYEE EVER MARRIED T O ANYONE OTHER THAN YOURSELF? ☐ YES ☐ NO

14. LIST ALL OF EMPLOYEE'S CHILDREN FROM THIS MARRIAGE WHO BE ENTITLED TO COMPENSATION (See attached information sheet for definition of chidren)

NAME	RELATION SHIP	DATE OF BIRTH	ADDRESS *(Include Zip Code)*

14a. LIST ALL OF EMPLOYEE'S CHILDREN FROM PRIOR MARRIAGES WHO MAY BE ENTITLED TO COMPENSATION:

NAME	RELATION SHIP	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)

CHILD	GUARDIAN	GUARDIAN*(Include Zip Code)*

16. LIST OTHER RELATIVES WHO WERE FULLY OR PARTIALLY DEPENDENT ON EMPLOYEE:
NAME RELATIONSHIP DATE OF BIRTH ADDRESS (Include Zip Code)

NAME	RELATION SHIP	DATE OF BIRTH	ADDRESS *(Include Zip Code)*

17. IF EMPLOYEE WAS EVER IN THE ARMED FORCES OF THE UNITED STATES, GIVE:
SERVICE NUMBER:
BRANCH OF SERVICE: N / A
PERIOD OF SERVICE:

18. IF APPLICATION HAS BEEN MADE FOR VETERANS ADMINISTRA-TION (VA BENEFITS BECAUSE OF EMPLOYEE'S DEATH, GIVE:
VA CLAIM NUMBER:
ADDRESS OF VA OFFICE WHERE CLAIM IS FILED:

19. IF APPLICATION HAS BEEN MADE FOR U.S. CIVIL SERVICE ANNUITY BECUSE OF EMPLOYEE'S DEATH, GIVE:
CSF CLAIM NUMBER:
DATE ANNUITY BEGAN:
AMOUNT PAID PER MONTH: $ _____

20. IF CLAIM HAS BEEN MADE AGAINST A THIRD PARTY 13ECAUSE OF EMPLOYEE'S DEATH, GIVE:
AMOUNT OF RECOVERY: $_____
NAME AND ADDRESS OF THIRD PARTY: John Jones
RR #3, Harpers Ferry, W . Vi rgini a

21. TOTAL BURIAL EXPENSE
$ _____

22. AMOUNT OF BURIAL EXPENCE PAID OR PAYABLE BY VA
$ _____

23. 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 ABOVESTRUE TO THE BEST OF MY KNOWLEDGE.

24. SIGJATURE OF PERSON FILING CLAIM	25. ADDRESS (Include Zip Code)	26. DATE (Mo., day, year)
	ALICE J Doe, 111-15th. Street, SE Washnington D.C. 20003	09/30/82

FORM CA-5
REV NOV 1974

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

Widow or Widower	• To qualify for benefits, 8 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 includes 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 fulltime 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, 407O 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.
Funeral/Burial Allowance	• Funeral and burial expenses up to a maximum of 5800 may be paid. Amount paid by the VA will be deducted. If death occurs away from 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 .

For sale by the Superintendent of Document, U.S. Government Printing Office
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Catalog Number L 7. FORM CA-6

INSTRUCTIONS FOR COMPLETING FORM CA-5, CLAIM FOR COMPENSTION BY WIDOW, WIDOWER, AN/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 the date of death, unless the decedent's immediate superior has actual knowledge of an on the job injury or death with 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, Letters 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 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; 4-14a, 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.

ATTENDING PHYSICIAN'S REPORT

1. NAME OF DECEASED LMPLOYEE (Last, first, middle)	2 DATE or DEATH (Mo., day, year)

3. WHAT HISTDRY OR INJURY OR EVPLOYI,IENT RELATED DISEASE AS GI VEN TD YOU?	4. IF TREATED FOR DISEASE, GIVE DIAGNOSIS.

5. IF DATN IAS NOT INSTAYTANOUS, DSSCRI- THE TRSATNT 'OU /nov	6. SHOW DATES ON WHICH TREAT MENT WAS GIVEN.

7. WHAT AS THE DIRECT CAUSI OF DEATH?

8. WHAT WERE THE CONTRIBUTORY CAUSES OF DEATH?

9. IN YOUR OPINION, WAS THE DEATH OF THE EMPLOYEE DUE TO THE INJURY AS REPORTED IN ITEM 3 AB0VE? ☐ 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)

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