Payment Of Compensation Without Award

(Longshore and Harbor Workers' Compensation Act, as extended)

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

Print | Reset | Submit

OMB No. 1215-0022

NOTE: This Notice is to be filed with the District Director when the first payment is made. A copy should be sent to the payee(s) AND to their attorney.

FOR OFFICE USE

1. OWCP No.
2. CARRIER'S No.

3. Name of injured person (First, middle, last - please print or type)

First Name * M.I. Last Name *

4. Address of injured person (Number, street, city, state and ZIP code) *

line 1: city: country:
line 2: state: zip:

5. Date of accident or first illness (Month, day, year)

6. Date disability began (Month, day, year)

7. Name of injured, or dependents of injured, to whom compensation will be paid

First Name * M.I. Last Name *

8.

Average weekly wage $ _____ multiplied by 2/3 compensation rate $ _____ *

(Mark if maximum rate is being paid) ☐ Yes ☐ No

9. Compensation will be paid from - Enter month, day, year. *

_____

until notice is given that payment has been stopped or suspended

I0. Date of first payment (Month, day, year.) *

11. Has medical care and treatment been provided by a physician or hospital chosen by the injured person? *

(Mark appropriate box) ☐ Yes ☐ No

12. Name and address of employer (Name, Number, street, city, state, ZIP code and country) *

name:
line 1: city: country:
line 2: state: zip:

13. Name and address of insurance carrier and/or claim administrator(Name, Number, street, city, state, ZIP code and country) *

name:
line 1: city: country:
line 2: state: zip:

14. Authorized signature *

Signature

15. Type or print title and name of person whose signature appears in item 14 * | Phone Number | 16. Date signed(mm-dd-yyyy) *

05/15/2008

Public Burden Statement

The following statement is made in accordance with the Privacy Act of 1974 (5 USC 552a) and the Paperwork Reduction Act of 1995, as amended. The authority for requesting the following information is 20CFR 702.234. Use of this form is optional, however furnishing the information is required in order to obtain and/or retain benefits. According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 1215-0022. The time required to complete this information collection is estimated to average 15 minutes per response, including the 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 U.S.Department of Labor, Division of Longshore and Harbor Workers' Compensation, Room C4315, 200 Constitution Avenue, N.W, Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE