

Report of Earnings

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

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs

www.dol.gov/esa/owcp/dlhwc/index.htm



OMB No.: 1215-0160

Instructions to Employee: You are required to complete and sign this form and return it to the employer/insurance carrier/special fund listed in item 4 within 30 days after receipt even if you have no earnings to report. (20 CFR 702.286) See page 2 for definition of "Earnings" and additional instructions. Loss of compensation benefits may result if this form is not completed and filed in accordance with instructions.

1. <div style="border: 1px solid black; height: 100px; width: 100%;"></div> <p style="text-align: center;">Name and Address of Employee (Type or print)</p>	2. OWCP No. 3. Carrier's No.
--	-------------------------------------

4. Name of Employer/Insurance Carrier/ Special Fund	5. Address of Employer/ Insurance Carrier/ Special Fund
---	---

6. Period For Which Earnings From Employment or Self-Employment Must be Reported	7. Have You Had Any Earnings From Employment or Self-Employment During the Period Shown in item 6? (See page 2 for definition of "Earnings")
From _____ To _____	[] Yes [] No

8. Complete the Following if You Had Earnings From Employment During the Period Shown in Item 6.

Name and Address of Employer	Periods of Employment		Amount Earned
	From	To	

9. Complete the Following If You Had Earnings From Self-Employment During The Period Shown in Item 6.

Type of Business or Service	Dates Performed		Gross Revenue Received	Profits or Net Earnings Received
	From	To		

10. I certify that the above information I have provided is true, complete and correct to the best of my knowledge and belief.

Signature and Print Name	Telephone No.	Date
--------------------------	---------------	------

IMPORTANT NOTICE

Section 31 (a)(1) of the Longshore Act, 33 U.S.C. 931 (a)(1), provides as follows: Any claimant or representative of a claimant who knowingly and willfully makes a false statement or representation for the purpose of obtaining a benefit or payment under this Act shall be guilty of a felony, and conviction thereof shall be punished by a fine not to exceed \$10,000, by imprisonment not to exceed five years, or both.

INSTRUCTIONS TO EMPLOYEE

You are required to report on this form all earnings from employment or self-employment earned during the period specified on page 1 of this form (20 CFR 702.286). An employee who fails to report his/her earnings when requested or knowingly and willfully omits or understates any part of such earnings may forfeit his/her right to compensation with respect to any period during which this report is required. Compensation forfeited, if already paid, shall be deducted from any future compensation which may be due in accordance with a schedule determined by the District Director of the Office of Workers' Compensation Programs, Division of Longshore and Harbor Workers' Compensation, having jurisdiction in the case. (33 U.S.C. 908(j)).

Earnings are defined as all monies received from any employment and includes but is not limited to wages, salaries, tips, sales commissions, fees for services provided, piecework and all revenue received from self-employment even if the business or enterprise operated at a loss or if the profits were reinvested.

An employer, insurance carrier, or the Director of the Office of Workers' Compensation Programs, Division of Longshore and Harbor Workers' Compensation (for those cases being paid from the Special Fund) may require an employee to file this report semiannually. The information provided will be used to determine entitlement to benefits.

FAILURE TO GIVE WRITTEN NOTICE MAY RESULT IN SOME LOSS OF BENEFITS.

PRIVACY ACT OF 1974 NOTICE

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a) you are hereby notified that (1) The Longshore and Harbor Workers' Compensation Act, (LHWCA) as amended and extended (33 U.S.C. 901 et seq.) 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 LHWCA. (3) Information may be given to the employer which employed the claimant at the time of injury, or to the insurance carrier or other entity which secured the employer's compensation liability. (4) Information may be given to physicians and other medical service providers for use in providing treatment or medical/vocational rehabilitation, making evaluations and for other purposes relating to the medical management of the claim. (5) Information may be given to the Department of Labor's Office of Administrative Law Judges (OALJ), or other person, board or organization, which is authorized or required to render decisions with respect to the claim or other matter arising in connection with 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 LHWCA to determine whether benefits are being and have been paid properly, and where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by law. (7) Failure to disclose all requested information may delay the processing of the claim, the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

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 20 CFR 702.285. 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 1215-0160. The time required to complete this informatin collection is estimated to average 10 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 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 C-4315, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.