Report of Injury Experience of Insurance Carrier or Self-Insured Employer

U.S. Department of Labor

Office of Workers' Compensatioon

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

Print Reset

This report is to be used to list all open cases as of the date of the report. The information provided will be used to determine the adequacy of a carrier's or self - insurer's security deposit.	Act: LS ☐ DB ☐ NF ☐ OC ☐ State:___________

Insurance Carrier or Self-Insured Employer's Name	Insurance Carrier/ Self- Insured Employer Address (Number, Street, City, State, ZIP Code) city st zip	Injury Year Jan.1-Dec.31	List all open cases as of Dec. 31, _____________	Date of this report

Social Security Number (a)	OWCP Case Number (b)	Name of Injured Employee (c)	Date of Injury (d)	Nature of Injury Use Abbreviations -Fx, spr, etc. (e)	Total Amount of Benefits Paid to date (f)	CY Compen-sation Paid (g)	CY Medical Paid (h)	Estimate of Future Compensation Payment (i)	Estimate of Future Medical Payments (Disability cases only) (j)	Estimate of Total Future Compensation Payments (i & j) (k)	Check Third Party Cases (l)	Check Fatal Cases (m)
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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 703.212(3) and 20 CFR 703.311(2). Use of this form is optional, however failure to submit the completed report may result in termination of your authorization to write insurance or be self-insured under the Act(s). 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 information collection is estimated to average 60 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, Washington, DC 20210.

FORM LS-274
Rev. April 2009

Privacy Act Notice

(1) The Longshore and Harbor Workers' Compensation Act (LHWCA), as amended and extended (33 U.S.C. 901 et seq.) LHWCA is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor which receives and maintains information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for the amount of benefits 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 the 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 matters 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.

Section 31 (a) (1) of the Longshore and Harbor Workers' Compensation 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 or conviction thereof shall be punished by a fine not to exceed $10,000, by imprisonment not to exceed five years, or both.

INSTRUCTIONS:

All carriers and self- insured employers are required to submit this report on an annual basis, as required by 20 CFR 703.212(3) and 20 CFR 703.311 (2). Detailed instructions for the completion of this form are published on the web at http://www.dol.gov/owcp/dlhwc/index.htm.

1. A separate report must be submitted for each act, each state and for each year of payments.
2. Show the carrier/self insurance authorization number on each report.
3. If the company has subsidiaries, separate report for each state, each act and each year of payment must be submitted for each subsidiary.
4. Each report must be listed chronologically by accident date and include:
   - Column a- the claimant's social security number;
   - Column b- the OWCP case number;
   - Column c- the name of the injured employee;
   - Column d- the date of injury;
   - Column e- the nature of injury;
   - Column f- the amount of compensation and medical payment paid through the reporting year;
   - Column g- the amount of compensation paid during the calendar year reported on form LS-513;
   - Column h- the amount of medicals paid during the calendar year reported on form LS-513;
   - Column i- the estimate of future compensation benefit payments;
   - Column j- the estimate of future medical benefit payments;
   - Column k- the estimate total compensation and medical payments expected to be paid in the future;
   - Column l- a checkmark if the case is a fatal case; and
   - Column m- a checkmark if the case is a third party case.
5. Each report should reflect a total for all estimated future payments for that act, state and reporting year.
6. A separate report showing the grand totals for all states by Act should also be submitted.
7. All submitted reports must include a separate notarized statement on company letter, signed by a corporate officer attesting to a completeness and accuracy of the information reported. This statement must also indicate the name and telephone number of the person to be contacted in the event there are questions.

The report should be addressed as follows:

US Department of Labor
OWCP/DLHWC, Room C-4315
200 Constitution Avenue, NW
Washington, DC 20210
Attn: Miranda Chiu, Acting Director, DLHWC

Failure to submit the complete report as outlined in these instructions may result in termination of your authorization to write insurance or be self-insured under the Act(s). This insurance or self insurance authorization cannot be transferred or assigned. Any change involving the corporate name, structure, ownership, organization, etc. may affect the insurance carrier/self insurer's authority and must be brought to the attention of this Office prior to the effective date of the event.

For further information and or assistance, please contact the Insurance Branch at 202-693-0039.