Notice of Final Payment or Suspension of Compensation Payments

Print Reset

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

INSTRUCTIONS: This notice must be filed with the District Director at the address in 3(a) within 16 days after compensation has been stopped or suspended. A copy of the completed form must be mailed to the claimant and the claimant's representative. Use of this form is mandatory. Failure to timely file this form shall result in assessment of a penalty as outlined in 20 CFR 702.236. This form is to be used to report disability or death compensation payments, as well as other statutory payments. The information will be used to verify the sufficiency of compensation paid under the Act.

OMB No.: 1240-0041
Expires: 05/31/2018

1. OWCP No.

2. Carrier's No.

3. Name and address of Employee or other beneficiary (Type or print)
Place within brackets

United States

3a. Central Mail Receipt site:
U.S. Department of Labor
Office of Workers' Compensation Programs
Division of Longshore and Harbor Workers' Compensation
400 West Bay Street, Suite 63A, Box 28
Jacksonville, FL 32202
or
Upload directly to the case file at: https://seaportal.dol-esa.gov

4. Name of employer

5. Address of employer

6. Date of Injury

7. Date employee first lost pay because of injury

7a. Date first check issued

8. Date physician found employee able to return to work

9. Date employee returned to work

10. Was compensation paid at the maximum rate? ☐ Yes ☐ No
Average weekly wage $ _____ multiplied by 2/3 = Compensation rate $ _____

11. State reason or reasons for termination or suspension of payments

12. Date last payment made

13. Date of this notice

14. **ENTER ALL PAYMENTS MADE ON ACCOUNT OF DISABILITY**

TYPE OF DISABILITY a	FROM (Mo., day, yr.) b	THROUGH (Mo., day, yr.) c	AMOUNT PAID PER WEEK d	NUMBER OF WEEKS PAID e	TOTAL f
Temporary total					
Temporary partial					
Permanent partial (non-schedule**)**					
Permanent partial (schedule loss) **Percent** _____ **Part of body** _____					
Permanent total					

Attach continuation sheet to show additional periods, rates and amounts: **TOTAL PAID:**

15. **ENTER ALL PAYMENTS MADE ON ACCOUNT OF DEATH**

BENEFICIARY'S NAME AND DATE OF BIRTH a	FROM (Mo., day, yr.) b	THROUGH (Mo., day, yr.) c	AMOUNT PAID PER WEEK d	NUMBER OF WEEKS PAID e	TOTAL f

Attach continuation sheet to show additional beneficiary's periods, rates and amounts: **TOTAL PAID:**

16. **ENTER OTHER PAYMENTS**

a. Section 8(i) Settlement: 1) Compensation 2) Medical benefits		e. Attorney fees	
b. Compensation for late payment per Sec. 14(e) or (f)		f. Funeral Expenses	
c. Interest		g. Sec. 44(c)(1) payment to the Special Fund	
d. Disfigurement		h. Commutation	

As verified by the signature below, this form was mailed to the claimant and claimant's representative.

17. Name of insurance carrier or self-insured employer and claim administrator

a. Address and phone number of person whose name is shown in Box 18

18. Signature of person authorized to sign for employer or carrier

19. Name and Title of person whose signature appears in Box 18

EMPLOYEE-PLEASE READ CAREFULLY	**Any claim for compensation, to be valid, must be filed IN WRITING with the District Director, OWCP, WITHIN ONE YEAR after the date of injury or date of last payment of compensation. If you have any impairment of the body, serious disfigurement, or other disability from the injury which may handicap you in securing or maintaining employment you should submit a claim to the U. S. Department of Labor as shown in 3a above. Please be sure to include the OWCP Case Number. For further instructions, please see the reverse side of this form.**

INSTRUCTIONS TO INJURED WORKER AND BENEFICIARY

A claim may be filed within one year after the injury or death (33 U.S.C. 913(a)). If compensation has been paid without an award, a claim may be filed within one year after the last payment. Time for filing a claim does not begin to run until the employee or beneficiary knows, or should have known by the exercise of reasonable diligence, of the relationship between the employment and the injury.

In cases involving occupational disease which does not immediately result in death or disability, a claim may be filed within two years after the employee or claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship between the employment, the disease, and the death or disability.

To file a claim for compensation benefits, complete and sign Form LS-203, Employee's Claim for Compensation or Form LS-262, Claim for Death Benefits. The forms can be obtained through the OWCP/DLHWC website at: http://www.dol.gov/owcp/dlhwc/lsforms.htm or by your servicing district office. The contact information is available on the OWCP/DLHWC website at: http://www.dol.gov/owcp/dlhwc/lscontactmap.htm.

Please be sure to include the OWCP Case Number and mail this form to the OWCP/DLHWC Central Mail Receipt site at the following address:

U. S. Department of Labor
Office of Workers' Compensation Programs
Division of Longshore and Harbor Workers' Compensation
400 West Bay Street, Suite 63A, Box 28
Jacksonville, FL 32202

Or upload the claim directly to the case file using the Secure Electronic Access Portal (SEAPortal).

Access the SEAPortal directly at: https://seaportal.dol-esa.gov

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PRIVACY ACT STATEMENT

Privacy Act of 1974 as amended (5 U.S.C. §552a), section §914(g) of Title 33 to the U.S. Code and 20 C.F.R. §702.235 authorizes collection of this information. The purpose of this information is to determine the final payment of compensation regarding the beginning and ending dates of payments, compensation rates, reason payments were terminated and types and amount of compensation payments under the Longshore and Harbor Workers' Compensation Act and its extensions (LHWCA). Completion of this form is mandatory and failure to provide the information may result in assessment of civil penalty (33 U.S.C. §914 (g)) against the employer. Additional disclosures of this information may be to: (1) The claimant and/or his representative. (2) 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. (3) 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. (4) 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. (5) Failure to disclose all requested information may delay the processing of the claim, the payment of additional 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 U.S.C. §522a) and the Paperwork Reduction Act of 1995, as amended. The authority for requesting the following information is 20 C.F.R. §702.251. 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 1240-0042. 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 Worker's Compensation, Room C4319, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND COMPLETED FORMS TO THIS OFFICE.