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| **Proposed LS-208 – Notice of Payments** | **Current LS-206 – Payment of Compensation without Award** | **Current LS-208 – Notice of Final Payment or Suspension of Compensation Payments** |
| 1. Date of Accident/Illness | 1. 5. Date of accident or first illness
 | 1. 6. Date of Injury
 |
| 2. Carrier’s No. | 2. Carrier’s No. | 2. Carrier’s No. |
| 3. OWCP No. | 1. OWCP No. | 1. OWCP No. |
| 4. Name of Injured Worker and Claimant If other than worker | 3. Name of Injured Person.7. Name of injured, or dependents of injured, to whom compensation will be paid | 3. Name and Address of Employee or other beneficiary |
| 5. Claimant’s Address | 4. Address of injured person | 5. Address of employer |
| 6. Compensation Disability Type | 9. Type of compensation paid, payment begin date, is the employer continuing to pay injured person’s salary, are these payments being made in lieu of compensation payments |  |
| 7. Date employee first lost time | 6. Date disability began |  |
| 8. Average weekly wage | 8. Average weekly wage |  |
| 9. Payment begin date | 9. Type of compensation paid, payment begin date, is the employer continuing to pay injured person’s salary, are these payments being made in lieu of compensation payments |  |
| 10. Employer continuing to pay the injured person’s salary? If so, are the salary continuation payments made in lieu of compensation payments? |  | 10. Was compensation paid at the maximum rate |
| 11. Date first check issued | 10. Date of first payment | 7. Date first check issued |
| 12. Type of notice: initial, interim, final | Form utilized for initial payment  | Form utilized for interim and final payment |
| 13. State reason for interim or final payment notice |  | 11. State reason or reasons for termination or suspension of payments |
| 14. Date last payment made |  | 12. Date last payment made |
| 15. Enter all payments made on account of disability (Table) |  | 14. Enter all payments made on account of disability (Table) |
| 16. Enter other payments (Table) |  | 16. Enter other payments (Table) |
| 17. Employer name, employer address | 12. Name and address of employer | 4. Name of employer5. Address of employer |
| 18. Name of insurance carrier or self-insured employer and administrator, address and phone number of person whose name is shown in Box 18 | 13. Name and address of insurance carrier and/or claim administrator | 17. Name of insurance |
| 19. Signature of person authorized to sign for employer or carrier | 14. Authorized signature | 18. Signature of person authorized to sign for employer or carrier |
| 20. Print name of authorized person  | 15. Type or print title and name of person whose signature appears in item 14 | 19. Name and title of person whose signature appears in Box 18 |
| 21. Date of notice | 16. Date signed | 13. Date of this notice |