Notice of Controversion of Right to Compensation

Print Reset

U.S. Department of Labor
Office of Workers' Compensation Programs
Longshore and Harbor Workers' Compensation

This report is required to obtain or retain benefits and is authorized by law and regulation (33 U.S.C. 914(d), (e); 20 C.F.R. §702.251). Failure to report when controverting right to compensation can result in liability for 10 percent additional compensation.

OMB No. 1240-0042
Expires: XX/XX/XXXX

Instructions: This form may be used by the employer/carrier to controvert the right to compensation. 33 U.S.C. 914(a) requires the employer to pay compensation promptly and without an award unless the right to such compensation is controverted by the filing of this form. Failure either to pay each installment of compensation, or controvert the right to such compensation, within fourteen days after it becomes due may result in liability for additional compensation equal to ten percent of each installment not paid when due (33 U.S.C. 914(d), (e)). If the right to compensation is controverted, this form should be submitted to the District Director through the OWCP/DLHWC Central Mail Receipt site or uploaded directly to the case file at: **https://seaportal.dol-esa.gov**, and the reasons for such controversion should be fully stated in item 12. A copy of the completed form must be mailed to the claimant and claimant's representative.

1. OWCP File No.

2. Employer File No.

3. Carrier File No.

4. Claimant's Name and Address
First Name M.I. Last Name
name:
line 1: line 2:
city: state: zip:
telephone: country: US

5. Employee's Name and Address if different from Claimant's
city: st: zip:
telephone: country: US

6. Employer's Name, Address and Phone Number
city: st: zip:
telephone: country: US

7. Carrier's Name, Address and Phone Number
city: st: zip:
telephone: country: US

8. Claim Filed or Injury Reported Under (check one)
☐ LHWCA ☐ OCSLA ☐ DBA
☐ DCWCA ☐ NFIA

9. Nature of Injury or Occupational Disease

10. Date of Injury (Month, Day, Year)

11. Date of Employer's First Knowledge of Injury (Month, Day, Year)

12. Issues in Dispute (Select one or more):
☐ Last Responsible Employer/Carrier ☐ Permanent Disability ☐ Medical Treatment
☐ Fact of injury – AOE/COE ☐ Temporary Disability ☐ Jurisdiction
☐ Average Weekly Wage ☐ Additional Compensation ☐ Other

Right to compensation is controverted for the following reason(s):

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

13. Authorized Signature

14. Print Name and Phone Number phone:

15. Title

16. Date of this Notice (Month, Day, Year)

Explanation to Employee	**This is notice that the employer (or its insurance carrier) makes objection to your right to benefits under the workers' compensation Act indicated in item 8 of this form, for the injury or death identified in items 9 and 10. Item 12 gives the reasons for this objection. If you believe you are entitled to workers' compensation benefits under the LHWCA and its extensions, or disagree with the grounds stated, please inform your servicing district office, giving reasons for your belief. 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 form 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

---

PRIVACY ACT STATEMENT

Privacy Act of 1974 as amended (5 U.S.C. §552a), section §914(d) of Title 33 to the U.S. Code and 20 C.F.R. §702.251 authorizes collection of this information. The purpose of this information is to inform the claimant of the reason(s) the insurance carrier or self-insured employer makes objection to paying compensation or medical benefits and to determine eligibility for the amount of benefits payable under the Longshore and Harbor Workers' Compensation Act and its extensions (LHWCA). Completion of this form is not mandatory; however, failure to provide the information may result in additional compensation benefits payable by the employer (33 U.S.C. §914 (e)). 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) Physicians and other medical service providers for use in providing treatment or medical/vocational rehabilitation, making evaluations and for other purposes relating to the management of the claim. (4) 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. (5) 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. (6) 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.