Application for Security Deposit Determination

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

Print Reset

OMB Form No. 1240-0005 Exp Date: XX/XX/XXXX

An insurance carrier authorized to write insurance for the payment of compensation under the Longshore and Harbor Workers' Compensation Act, 33 USC 901-950, or any of its extensions must fully secure its payment obligations under these statutes by depositing security in an amount determined by the Office of Workers' Compensation Programs. On an annual basis, each authorized carrier (or a carrier seeking authorization) must complete this application. The information in this application will help the Office determine the security amount necessary to fully secure the carrier's payment of compensation, medical services and supplies, and any other obligations it has under these statutes.

No authorization for insurance carriers will be approved unless a complete application form has been received. (33 USC 932; 20 CFR 703.203). Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

INSTRUCTIONS: Please complete all items. If your answer requires more space than provided, please attach a separate sheet(s) for each and identify the item you are answering. Information contained in this application will not be open to public inspection.

You must also complete Form LS-274, Report of Injury Experience, and submit it as part of this application.

Please submit the completed application and any attachments to: US Department of Labor, Office of Workers' Compensation Programs, Division of Longshore and Harbor Workers' Compensation, Room C-4319, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

1. Application Period: January 1, _____ to December 31, _____

2. Insurance Carrier's Name and Address (Principal Office)

Sequence #: EIN:

3. Check all acts that you are authorized to write insurance under:

A. ☐ Longshore and Harbor Workers' Compensation Act (LHWCA) (33 USC 901)

B. ☐ Nonappropriated Fund Instrumentalities Act (NAFI) (5 USC 8171)

C. ☐ Defense Base Act (DBA) (42 USC 1651)

D. ☐ Outer Continental Shelf Lands Act (OCSLA) (43 USC 1331)

4. Telephone Number:

5. Facsimile Number:

6. Are you applying for an exemption from the security deposit requirements (see 20 C.F.R. 703.203(a)(1))? ☐ Yes ☐ No

If you checked yes, you must attach documentation establishing your current rating and your rating for the immediately preceding year from each insurance rating service designated by OWCP and posted on the Internet at http://www.dol.gov/owcp/dlhwc/index.htm.

If you checked no, proceed to number 7.

7. Columns a and b: Report your outstanding payment obligations under the LHWCA, and /or its extensions, for each state in which the liabilities arose. (Please base your report on your completed form LS-274, Report of Injury Experience.) **Column c:** List the percentage of the liabilities reported in columns a and b based on the current status of each state's guaranty fund's protection for Longshore benefits: The Office's determination of each state's coverage was transmitted to you with this application form. It is also available on the internet at http://www.dol.gov/owcp/dlhwc/index.htm. If you use a percentage different from the Office's determination for any particular state, you should submit documentation supporting your conclusion. **Column d:** Enter deposit amount you believe will fully secure your obligations in each state. **NOTE:** A separate LS-274 must be submitted for each state along with an attachment stating the information submitted is "certified as true and accurate" and must bear the notarized signature of a corporate officer.

a. STATE	b. TOTAL OBLIGATIONS	c. PERCENT UNSECURED	d. ESTIMATED DEPOSIT

8. Total estimated security deposit amount: $ _____

OMB No. 1240-0005

I certify that I am an official of the applicant, duly authorized to file this application. I have carefully examined the statements made on the application, including the information contained in any additional sheets attached, and certify that the information supplied is true. I agree to inform the Office immediately of any changes that render the information I have supplied here incomplete, inaccurate or misleading.

Signature _____ Date _____

Official's Name and Title (Printed): _____

If insurance carrier is a corporation, affix Corporate Seal.

DO NOT WRITE IN THE SPACE BELOW

8. Date Application Received _____

PUBLIC BURDEN STATEMENT

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. Public reporting burden for this collection of information is estimated to average 1 hour per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Use of this form is optional, however furnishing the information is required in order to obtain and/or retain benefits (20CFR 703.203). Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, 200 Constitution Avenue, N.W., Room C-4319, Washington, D.C. 20210, and reference the OMB Control Number.