CARRIER'S REPORT OF ISSUANCE OF POLICY

Print Reset

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

Form LS-570 is used by authorized carriers to report the policy of insurance issued for each insured employer. This form is to be sent to the Deputy Commissioner in the compensation district indicated by the employer's address. Section 32 (a) of the Longshore and Harbor Workers' Compensation Act (33 USC 932(a)), and its extensions requires every employer to secure the payment of compensation under this Act either (1) by insuring and keeping insured the payment of such compensation with any insurance company authorized by the Secretary, to insure payment of compensation under this Act; or (2) receiving an authorization from the Secretary to pay such compensation directly.

OMB No.: 1240-0004
Expiration Date: 07/31/2022

1. Date

2. Jurisdiction (Act or Extension)
- ☐ Longshore and Harbor Workers' Compensation Act
- ☐ Defense Base Act
- ☐ Outer Continental Shelf Lands Act
- ☐ Non-Appropriated Funds Instrumentalities Act

Carrier Details

3. Insurance Carrier Name

4. Carrier Federal Employer Identification Number (FEIN)

Policy Details

5. Policy Number

6. Effective Date

7. Expiration Date

8. Prior Policy Number

9. Governing Class

10. Total Payroll

Employer Details

11. Employer Name and Address

12. Employer FEIN

13. Employer Phone Number

14. Authorized Signature

Title

Send completed form to USDOL/OWCP/DLHWC, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210

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 5 minutes 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. (20 CFR 703.116). 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, NW, Room S-3229, Washington, D.C. 20210, and reference the OMB Control Number.