# Request for Intervention

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

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| You must use this form to request intervention from the Office of Workers' Compensation Longshore Program. The District Suboffice has discretion on what action to take based on the request and documentation in the file. You must send a copy of the completed form to all parties and their representatives. | OMB No.: 1240-0058<br>Expires: 03/31/2023 |

Submit form to the OWCP/DFELHWC Central Mail Receipt site at the following address:
U.S. Department of Labor, Office of Workers' Compensation Programs
DFELHWC
400 West Bay Street, Suite 63A, Box 28
Jacksonville, FL 32202

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

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

| 1. Date of Accident/Illness: | 2. Carrier's No. | 3. OWCP No. |
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4. Name of Injured Worker and Claimant *if other than injured worker*

5. Type of Intervention Requested *(OWCP reserves the right to make a final determination)*

☐ Non-Conference ☐ Informal Conference

| 6. Employer | 7. Insurance Carrier |
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8. Name, Address and Phone Number of Party Requesting Intervention

9. Briefly state the facts of the claim:

10. List the issues the parties have reached agreement on:

11. Check Issues Requiring Intervention and attach position paper with supporting documents:

☐ Occurrence of Injury
☐ Responsible Employer/Carrier
☐ Jurisdiction/Situs/Status
☐ Average Weekly Wage
☐ Additional Compensation
☐ Temporary Disability
☐ Permanent Disability
☐ Medical
☐ Special Fund Modification
☐ Other _____

12. Describe efforts made to resolve issue(s):

As verified by the signature below, this form was sent to all opposing parties and their representatives

| 13. Print Name | 14. Signature | 15. Date (Month, Day, Year) |
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| | | |

Print Reset

**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 burden for this collection of information is estimated to average 10 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 required to request intervention by the Office of Workers' Compensation Longshore Program. See 20 C.F.R. 702.301, 702.311. 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-3524, Washington, D.C. 20210 and reference the OMB Control Number. Note: Please do not return the completed LS-7 to this address.

**DO NOT SEND COMPLETED FORMS TO THIS OFFICE.**

PRIVACY ACT STATEMENT

The following information is provided in accordance with the Privacy Act of 1974, as amended, 5 USC 552a. (1) This collection of information is authorized under the Longshore and Harbor Workers' Compensation Act (LHWCA) and its extensions. (2) The information collected, which includes a list of disputed issues between the parties to the compensation claim, will be used to determine whether and what level of intervention by the Office of Workers' Compensation Longshore Program would help resolve the disputed issues. (3) Completion of this form is required to request intervention by the Office of Workers' Compensation Longshore Program. (4) Disclosures of this information may be made to: the claimant and his or her representative(s); the employer, the insurance carrier or other entity that secured the employer's compensation liability, and their representative(s); any other entity that may be liable for the payment of compensation; the Department of Labor's Office of Administrative Law Judges (OALJ), or other person, board or organization, authorized or required to render decisions on claims or other matters arising in connection with a claim; Federal, state and local agencies 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; and other individuals, their representatives, and government agencies enforcing a legal obligation for alimony or child support. (5) Failure to provide the information on this form may delay processing of the claim, the payment of benefits, or may result in an unfavorable decision or reduced level of benefits. (6) This information is included in two Systems of Records, DOL/OWCP-3, 4, published at 81 Federal Register 25765, 25859-61 (April 29, 2016), or as updated and republished.