# Settlement Approval Request Section 8(i)

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

| You must use this form to request approval of a settlement under Section 8(i) of the Longshore and Harbor Worker's Compensation Act and its Extensions. You must attach a fully executed 8(i) settlement agreement. | OMB No.: 1240-0058<br>Expires: 03/31/2023 |
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Submit form and attachments to the OWCP/DLHWC Central Mail Receipt site by certified mail with return receipt requested or commercial delivery service with tracking capability 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 directly to the case file using the Secure Electronic Access Portal (SEAPortal)

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

You must include the following in the 8(i) settlement agreement: Brief summary of facts; Issues in dispute; Claimant's current work status; Medical reports describing injuries, impairment, and date of maximum medical improvement; Anticipated future medical treatment, the costs thereof, and medical paid in the last three years; Collateral sources for future medical treatment, if medical benefits are being settled; Explanation of why the settlement is adequate and not signed under duress; and Signatures of all parties. The application must be self-sufficient when read on its own without any background information. See 20 C.F.R 702.242, 702.243.

| 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. Claimant's Telephone Number *(required if claimant is not represented by an attorney)*

| 6. Average Weekly Wage | 7. Compensation Rate |
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| 8. Settlement Amount for Compensation (Provide the Case # and Amount for Each Case – up to 4 cases) | | |
| | | |
| 9. Settlement Amount for Medical Treatment (Provide the Case # and Amount for Each Case – up to 4 cases) | | |
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10. Are there any liens? If so, signature(s) are required from lien holder(s) ☐ Yes ☐ No

11a. Are Attorney Fees resolved *(itemized fee petition must be attached)* ☐ Yes ☐ No

11b. If yes, amount agreed upon ______________________

12. Total Amount Due to Claimant if Approved:

13. Have the Parties considered Medicare Secondary Payer Act? ☐ Yes ☐ No

## 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 20 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 approval of a settlement by the Office of Workers' Compensation Longshore Division under 33 U.S.C. 908(i) and 20 C.F.R. 702.241-702.243. 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. Note: Please do not return the completed LS-8 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) This information will be used to determine the adequacy of settlements agreed to under the LHWCA. (3) Completion of this form is required to request approval of a settlement 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); 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 settlement request, 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.