About Form CA-7

File a CA-7

When should I file?

- If you have an OWCP case number and have sustained wage loss, you should file a Form **CA-7** to claim compensation for periods of disability or time lost due to medical appointments and treatment.
- If wage loss continues, beyond the initial claim for compensation, you should submit subsequent **CA-7** forms each two weeks.
- You may also file a claim for a Schedule Award using form **CA-7**.

What do I need?

- You only need an OWCP case number in order to file a **CA-7**.
- If you filed your initial claim (**CA-1** or **CA-2**) through ECOMP, you can access that case via your Employee Dashboard in ECOMP.
- If you did not file your initial claim through ECOMP, you can locate an existing case from your Employee Dashboard by choosing the option to "Start a new **CA-7** based on a case not listed here."
- Note - You must submit medical evidence to support disability for any period claimed. You can upload any supporting documentation, including this medical evidence, while filing the **CA-7** or at any time thereafter via ECOMP.

Are other forms needed?

- If you file a Form **CA-7** for intermittent hours or days, you should also complete form **CA-7a (Time Analysis Form)**. This can be done through ECOMP.
- If you are claiming leave buy back, Form **CA-7b (Leave Buy Back Worksheet/Certification and Election)** will also be needed. Your employing agency can assist with filing this form. NOTE - You cannot file a Form **CA-7b** through ECOMP. You can however, find the **CA-7b** on DFEC's website. Once completed, the document can be uploaded to your OWCP case through ECOMP's electronic document submission feature and associated with a **CA-7** submitted through ECOMP.

How do I file the form?

The process for filing a form involves completing several form sections made up of smaller form-filing steps. These individual steps can be viewed in the navigation bar on the left. Unless otherwise noted, all of the fields in the form must be completed. The form may be saved at any time, and completed later. Once the form has been submitted, it will be reviewed by the employee's supervisor and/or the Agency Reviewer before submission to OWCP.

OMB No. 1240-0046 (Expires: 10-31-2014) Privacy Act and Public Burden Statements

The Office of Management and Budget (OMB) control number displayed on this data collection instrument has an expiration date of 10/31/2014; however, in accordance with the requirements of the Paperwork Reduction Act (44 U.S.C. 3501), the Department has submitted a request to the OMB to extend this expiration date for another three years. Therefore, pursuant to 5 C.F.R. § 1320.10 (e)(2), the Department is authorized to continue collecting this information after the displayed expiration date so long as it remains under review at the OMB. Once the OMB takes action on the aforementioned extension request, the new expiration date will be displayed on the data collection instrument.

File a CA-7

Base Claim for Compensation upon Existing Case Number

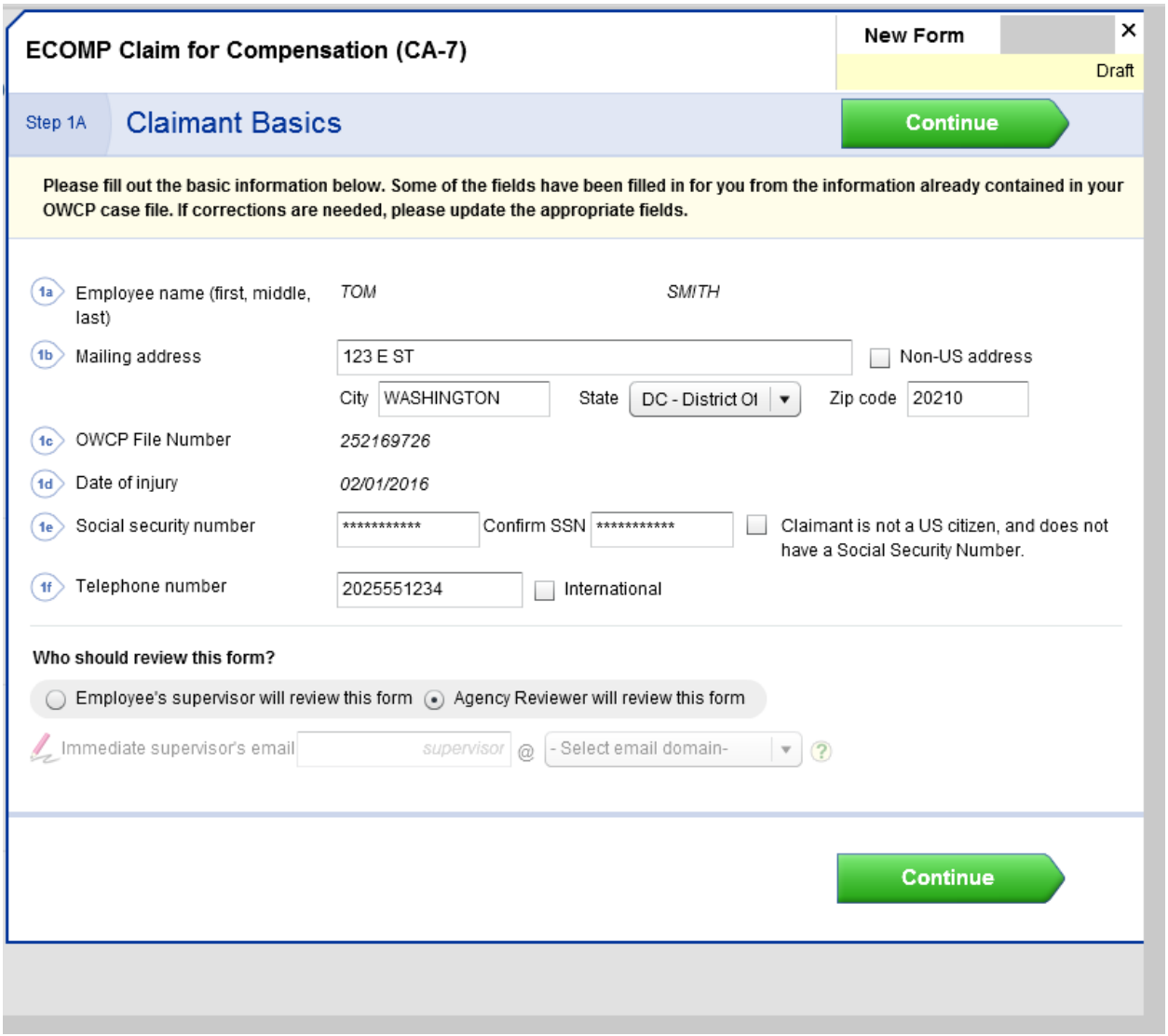
Your CA-7 will be based upon this case.

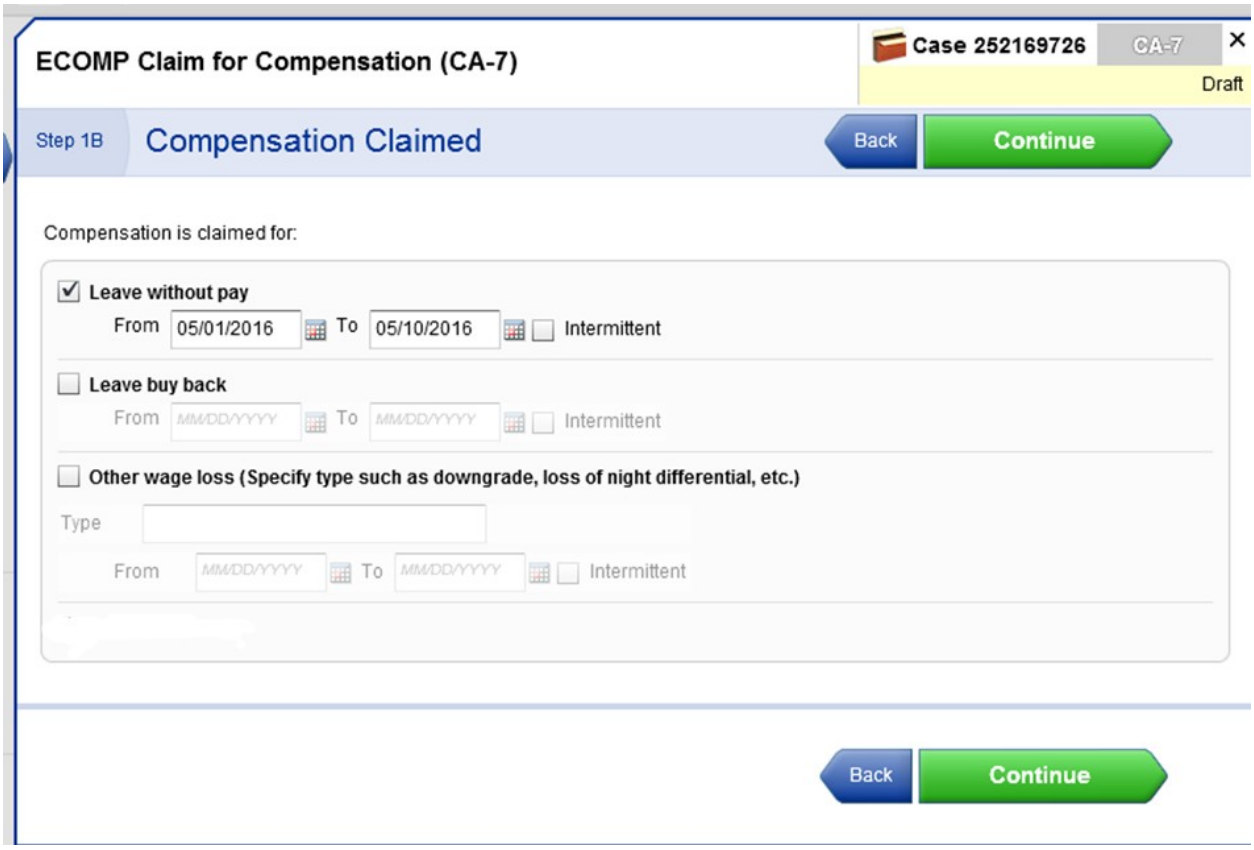
Case 252169726 | ECN 2487018 | CA-1 | Case created by DFEC

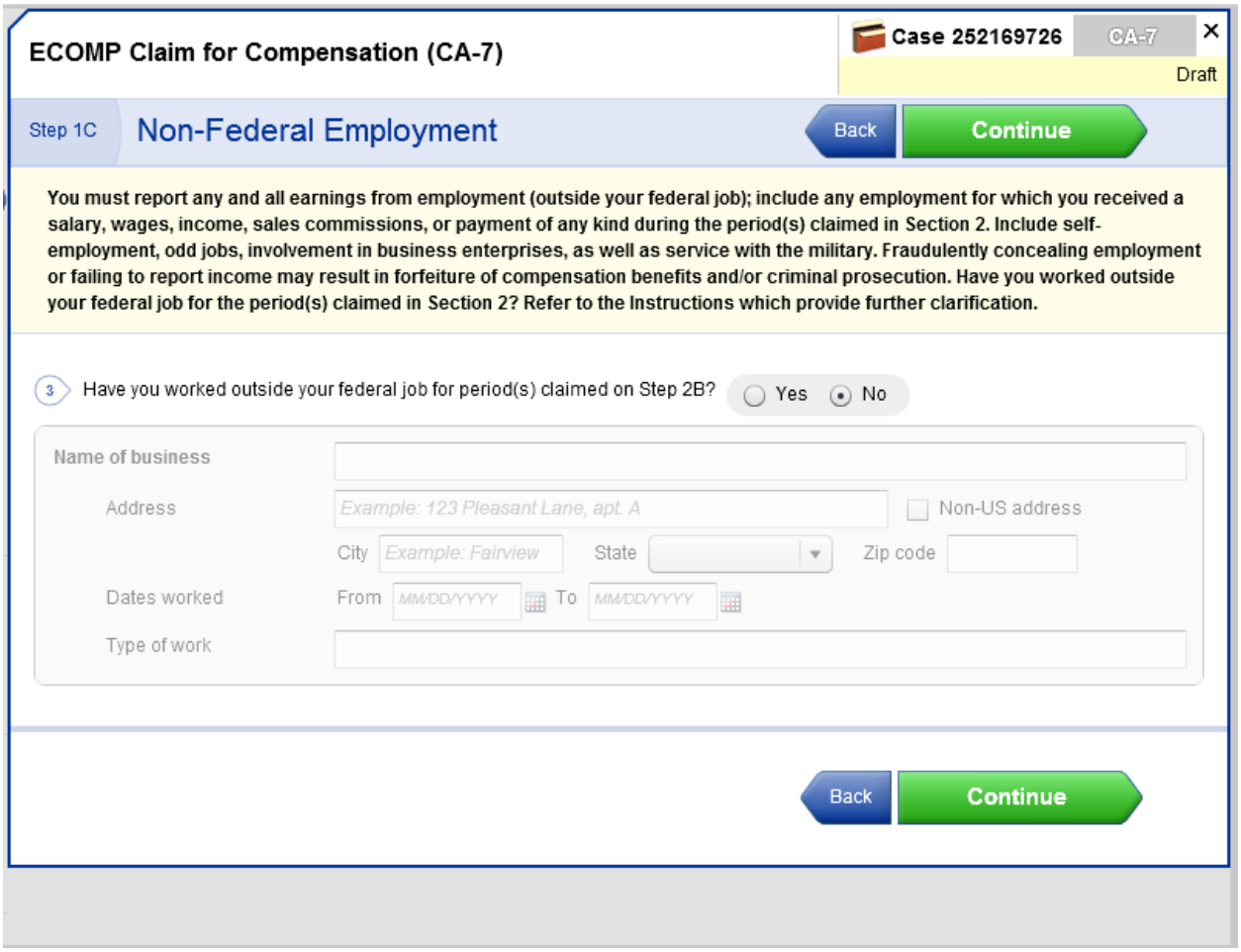
Employee	**Tom Smith**	Date of event	02/01/2016
Organization	OWCP TEST ONLY	Initiated	04/14/2016

Not the right case?
Locate a different case

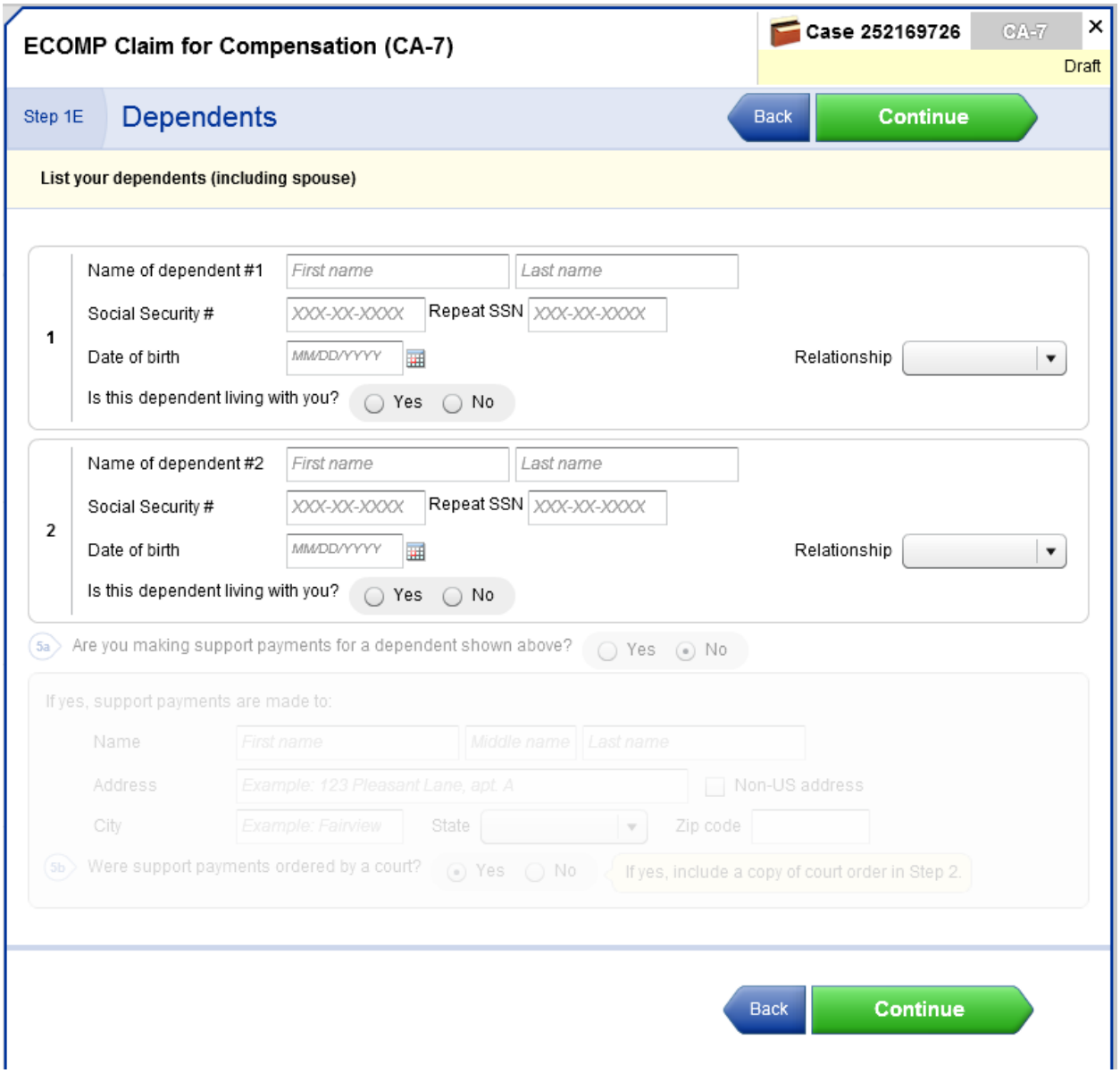
Continue

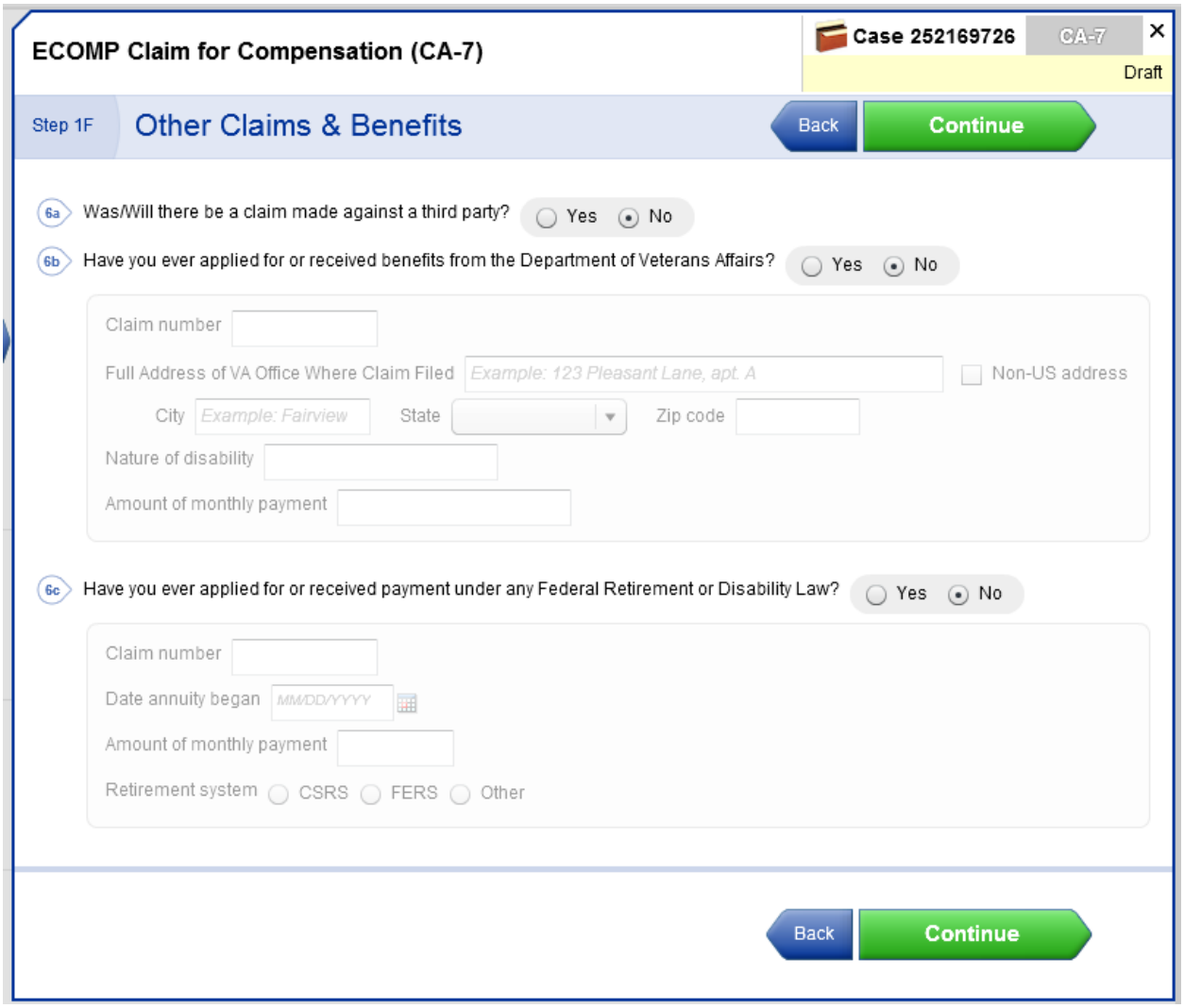

ECOMP Claim for Compensation (CA-7)
New Form
Draft
Step 1A
Claimant Basics
Continue
Please fill out the basic information below. Some of the fields have been filled in for you from the information already contained in your OWCP case file. If corrections are needed, please update the appropriate fields.
1a
Employee name (first, middle, last)
TOM
SMITH
1b
Mailing address
123 E ST
Non-US address
City
WASHINGTON
State
DC - District Of
Zip code
20210
1c
OWCP File Number
252169726
1d
Date of injury
02/01/2016
1e
Social security number
****
Confirm SSN
****
Claimant is not a US citizen, and does not have a Social Security Number.
1f
Telephone number
2025551234
International
Who should review this form?
Employee's supervisor will review this form
Agency Reviewer will review this form
Immediate supervisor's email
supervisor
@
- Select email domain-
Continue

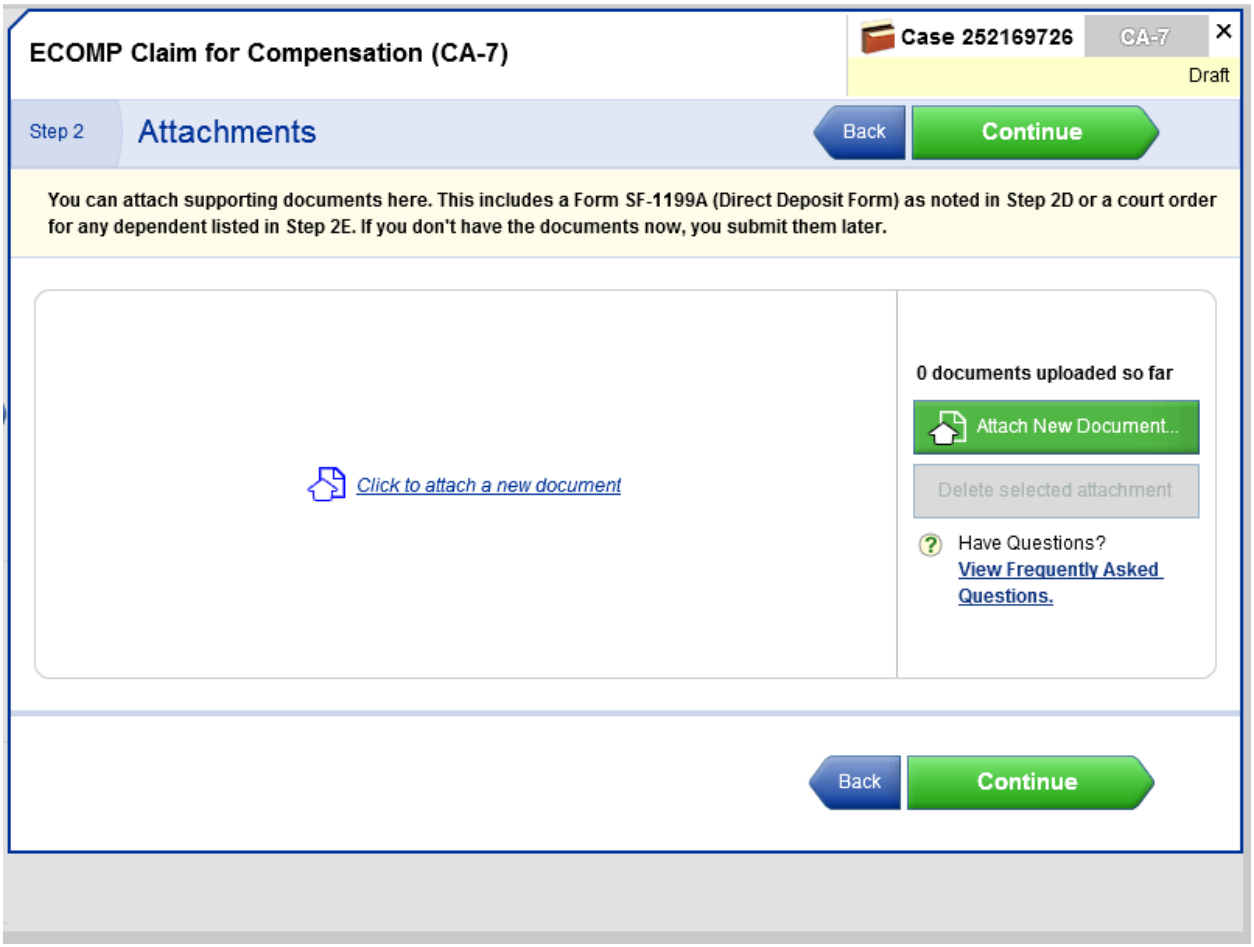

ECOMP Claim for Compensation (CA-7)
Case 252169726
CA-7
Draft
Step 1B
Compensation Claimed
Back
Continue
Compensation is claimed for:
Leave without pay
From 05/01/2016 To 05/10/2016 Intermittent
Leave buy back
From MM/DD/YYYY To MM/DD/YYYY Intermittent
Other wage loss (Specify type such as downgrade, loss of night differential, etc.)
Type
From MM/DD/YYYY To MM/DD/YYYY Intermittent
Back
Continue

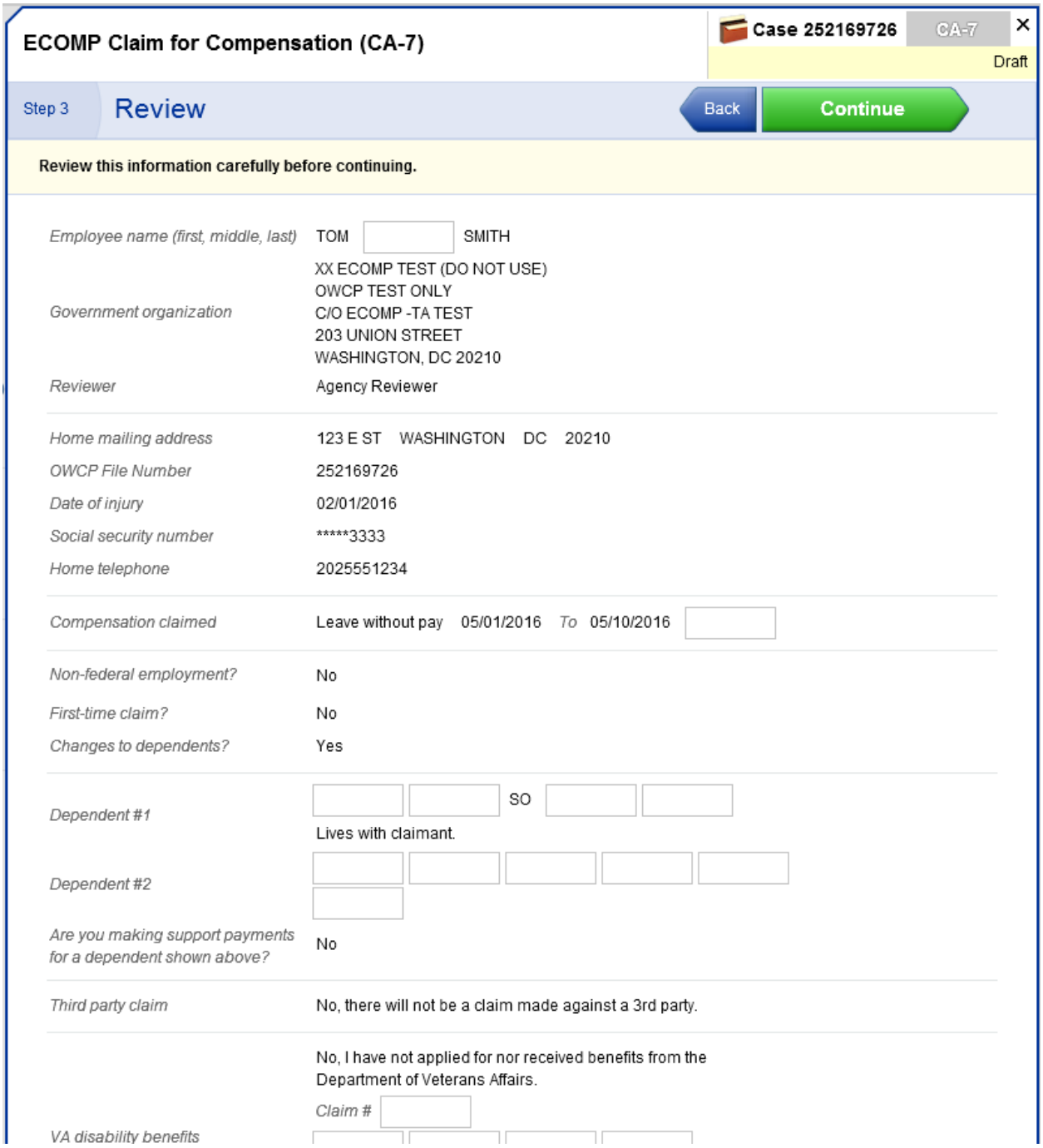

ECOMP Claim for Compensation (CA-7)
Case 252169726
CA-7
Draft
Step 1C
Non-Federal Employment
Back
Continue
You must report any and all earnings from employment (outside your federal job); include any employment for which you received a salary, wages, income, sales commissions, or payment of any kind during the period(s) claimed in Section 2. Include self-employment, odd jobs, involvement in business enterprises, as well as service with the military. Fraudulently concealing employment or failing to report income may result in forfeiture of compensation benefits and/or criminal prosecution. Have you worked outside your federal job for the period(s) claimed in Section 2? Refer to the Instructions which provide further clarification.
3
Have you worked outside your federal job for period(s) claimed on Step 2B?
Yes
No
Name of business
Address
Example: 123 Pleasant Lane, apt. A
Non-US address
City
Example: Fairview
State
Zip code
Dates worked
From
MM/DD/YYYY
To
MM/DD/YYYY
Type of work
Back
Continue

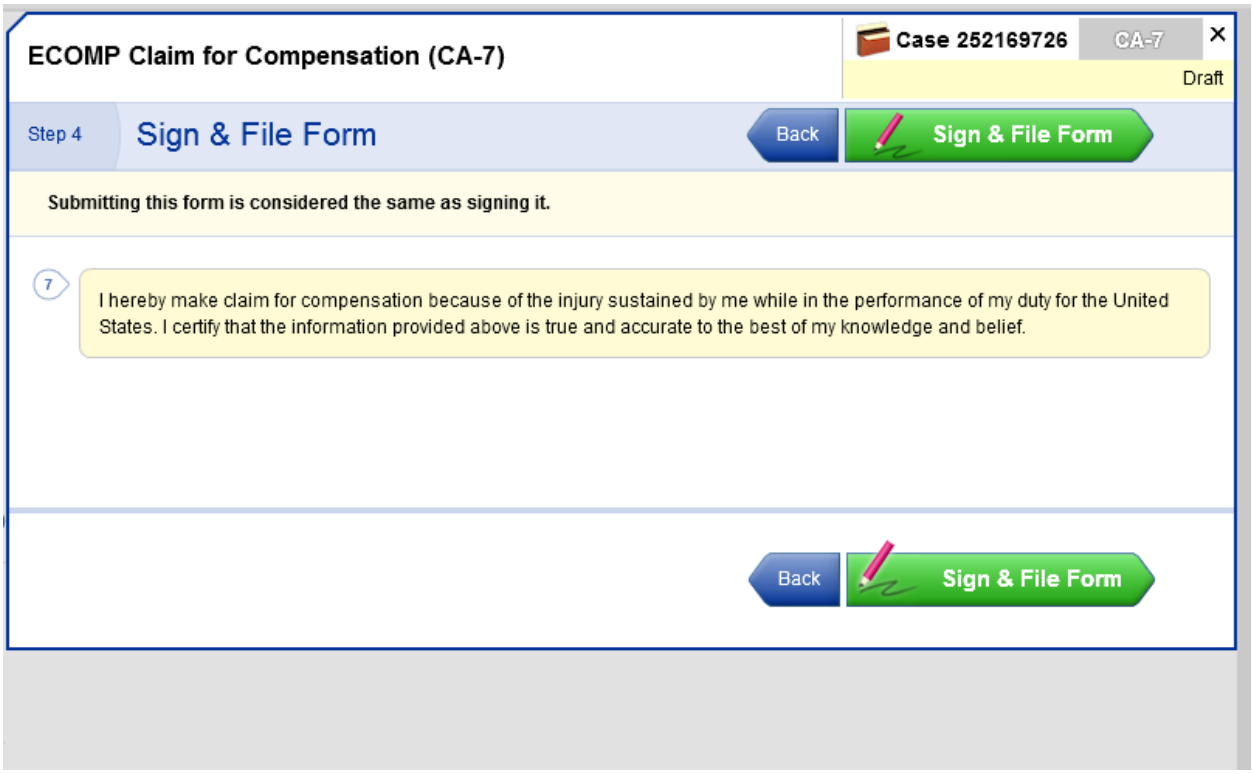

ECOMP Claim for Compensation (CA-7)
Case 252169726
CA-7
Draft
Step 1D
First Claim for Injury
Back
Continue
Has there been any change in your dependents, or has your direct deposit information changed, or has there been a claim filed with U.S. Civil Service Retirement, another federal retirement or disability law, or with the Department of Veterans Affairs since your last CA-7 claim?
Yes
No
Steps E and F have been enabled in the navigator at left. After filing this form you should also file new Form SF-1199A, "Direct Deposit Sign-up."
Back
Continue

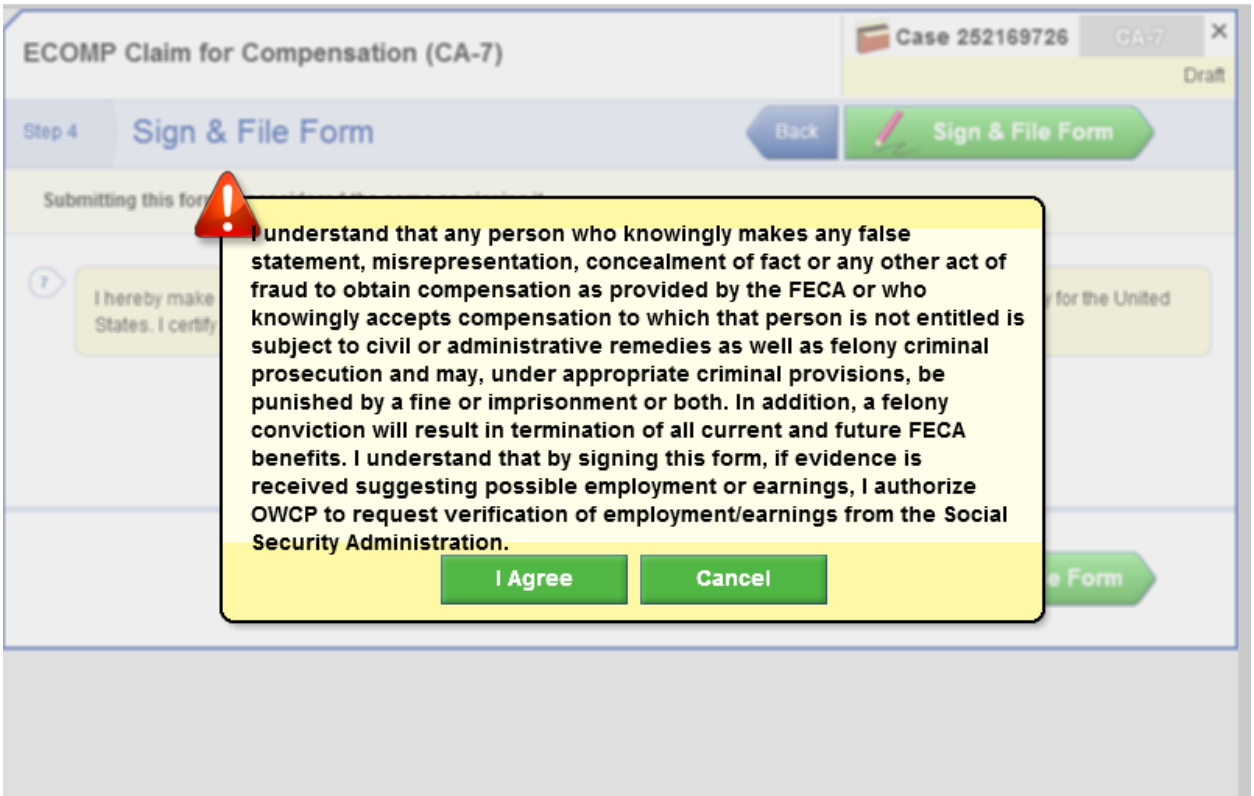

ECOMP Claim for Compensation (CA-7)
Case 252169726
CA-7
Draft
Step 1E
Dependents
Back
Continue
List your dependents (including spouse)
1
Name of dependent #1
First name
Last name
Social Security #
XXX-XX-XXXX
Repeat SSN
XXX-XX-XXXX
Date of birth
MM/DD/YYYY
Relationship
Is this dependent living with you?
Yes
No
2
Name of dependent #2
First name
Last name
Social Security #
XXX-XX-XXXX
Repeat SSN
XXX-XX-XXXX
Date of birth
MM/DD/YYYY
Relationship
Is this dependent living with you?
Yes
No
5a
Are you making support payments for a dependent shown above?
Yes
No
If yes, support payments are made to:
Name
First name
Middle name
Last name
Address
Example: 123 Pleasant Lane, apt. A
Non-US address
City
Example: Fairview
State
Zip code
5b
Were support payments ordered by a court?
Yes
No
If yes, include a copy of court order in Step 2.
Back
Continue

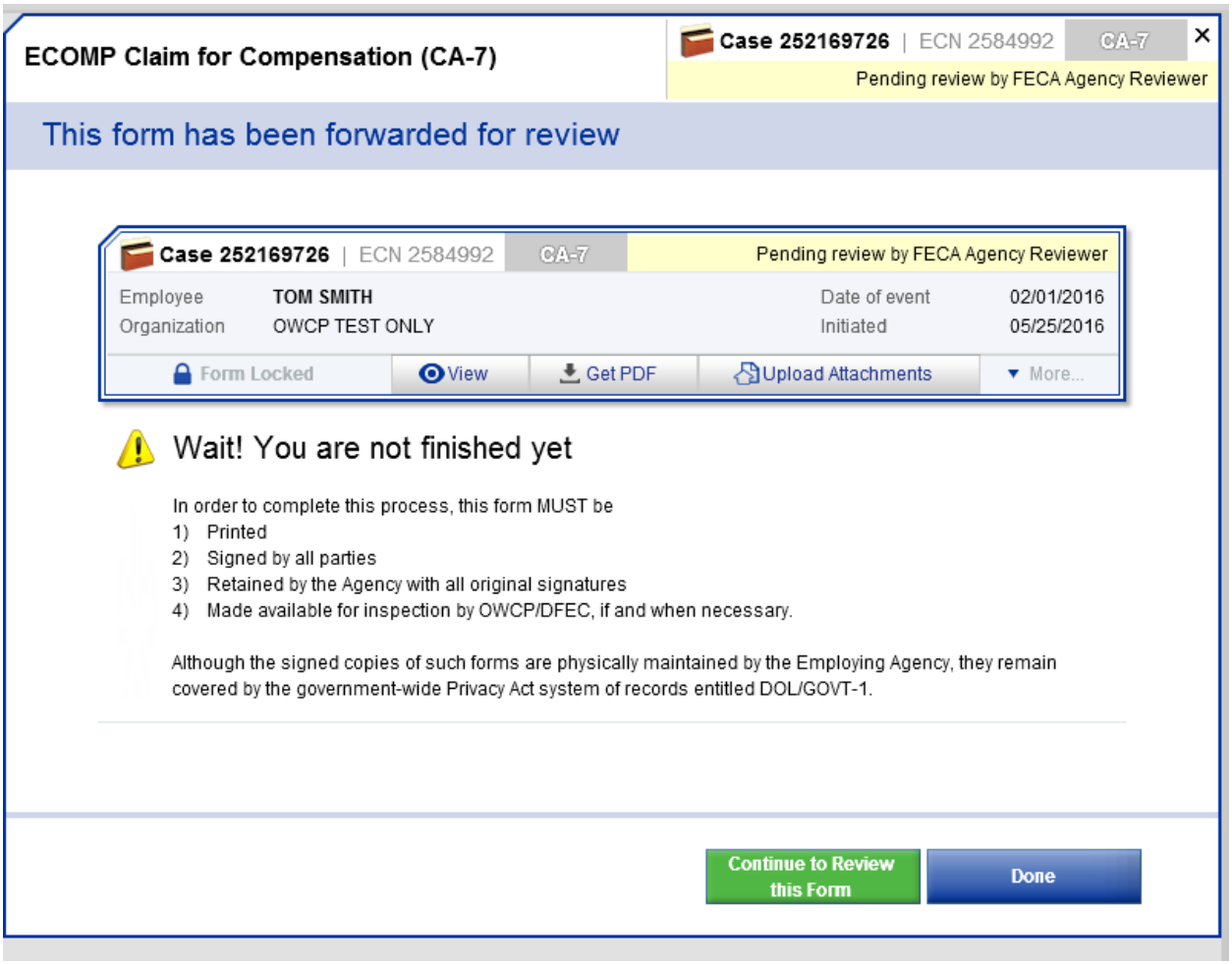

ECOMP Claim for Compensation (CA-7)
Case 252169726
CA-7
Draft
Step 1F
Other Claims & Benefits
Back
Continue
6a
Was/Will there be a claim made against a third party?
Yes
No
6b
Have you ever applied for or received benefits from the Department of Veterans Affairs?
Yes
No
Claim number
Full Address of VA Office Where Claim Filed
Example: 123 Pleasant Lane, apt. A
Non-US address
City
Example: Fairview
State
Zip code
Nature of disability
Amount of monthly payment
6c
Have you ever applied for or received payment under any Federal Retirement or Disability Law?
Yes
No
Claim number
Date annuity began
MM/DD/YYYY
Amount of monthly payment
Retirement system
CSRS
FERS
Other
Back
Continue

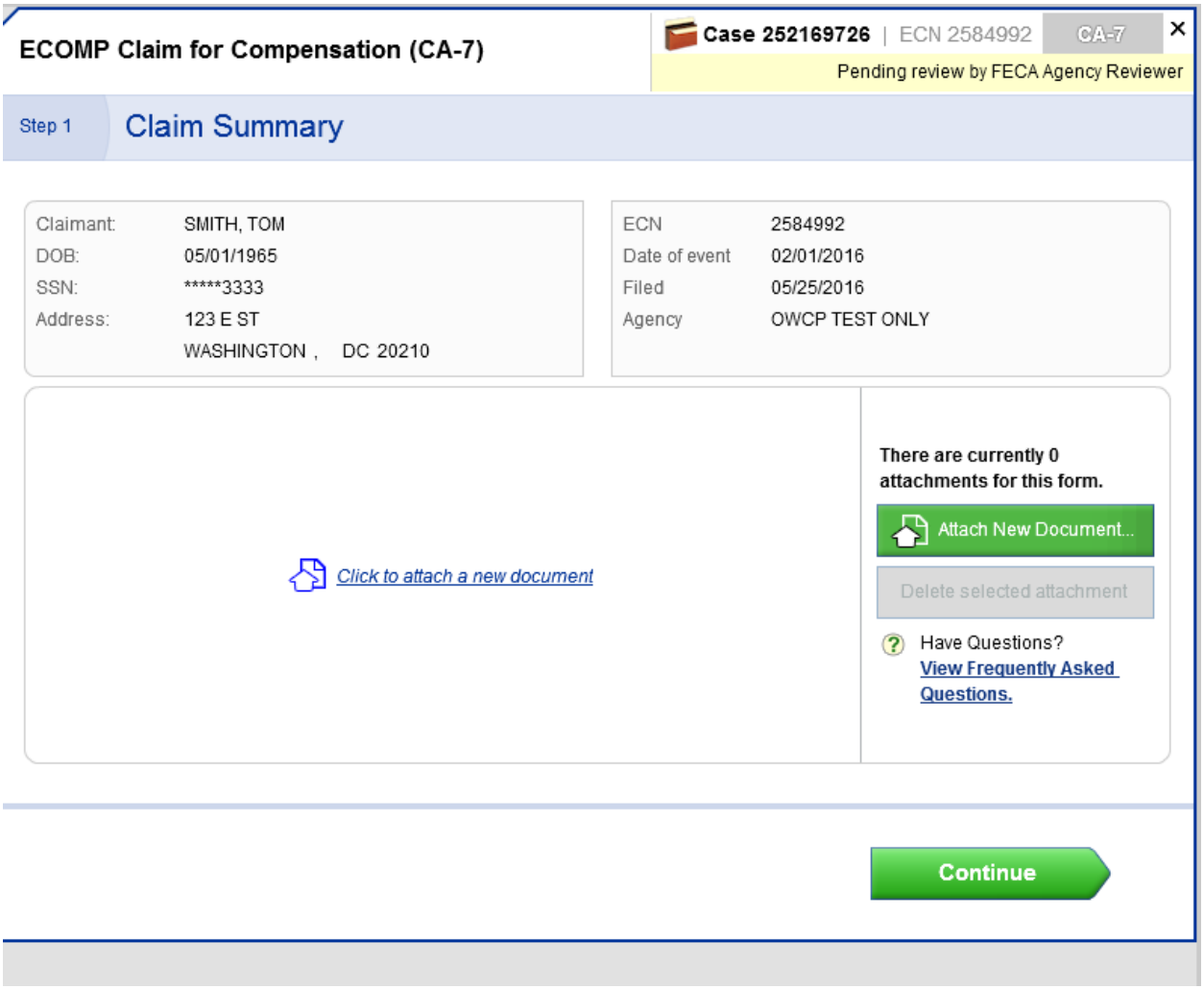

ECOMP Claim for Compensation (CA-7)
Case 252169726
CA-7
Draft
Step 2
Attachments
Back
Continue
You can attach supporting documents here. This includes a Form SF-1199A (Direct Deposit Form) as noted in Step 2D or a court order for any dependent listed in Step 2E. If you don't have the documents now, you submit them later.
Click to attach a new document
0 documents uploaded so far
Attach New Document...
Delete selected attachment
Have Questions?
View Frequently Asked Questions.
Back
Continue


ECOMP Claim for Compensation (CA-7)
Case 252169726
CA-7
Draft
Step 3
Review
Back
Continue
Review this information carefully before continuing.
Employee name (first, middle, last)
TOM
SMITH
Government organization
XX ECOMP TEST (DO NOT USE)
OWCP TEST ONLY
C/O ECOMP -TA TEST
203 UNION STREET
WASHINGTON, DC 20210
Reviewer
Agency Reviewer
Home mailing address
123 E ST WASHINGTON DC 20210
OWCP File Number
252169726
Date of injury
02/01/2016
Social security number
*****3333
Home telephone
2025551234
Compensation claimed
Leave without pay 05/01/2016 To 05/10/2016
Non-federal employment?
No
First-time claim?
No
Changes to dependents?
Yes
Dependent #1
SO
Lives with claimant.
Dependent #2
Are you making support payments for a dependent shown above?
No
Third party claim
No, there will not be a claim made against a 3rd party.
No, I have not applied for nor received benefits from the Department of Veterans Affairs.
Claim #
VA disability benefits


ECOMP Claim for Compensation (CA-7)
Case 252169726
CA-7
Draft
Step 4
Sign & File Form
Back
Sign & File Form
Submitting this form is considered the same as signing it.
7
I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States. I certify that the information provided above is true and accurate to the best of my knowledge and belief.
Back
Sign & File Form


ECOMP Claim for Compensation (CA-7)
Case 252169726
Draft
Step 4
Sign & File Form
Back
Sign & File Form
I understand that any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both. In addition, a felony conviction will result in termination of all current and future FECA benefits. I understand that by signing this form, if evidence is received suggesting possible employment or earnings, I authorize OWCP to request verification of employment/earnings from the Social Security Administration.
I Agree
Cancel


ECOMP Claim for Compensation (CA-7)
Case 252169726 | ECN 2584992 CA-7
Pending review by FECA Agency Reviewer
This form has been forwarded for review
Case 252169726 | ECN 2584992 CA-7
Pending review by FECA Agency Reviewer
Employee TOM SMITH
Organization OWCP TEST ONLY
Date of event 02/01/2016
Initiated 05/25/2016
Form Locked
View
Get PDF
Upload Attachments
More...
Wait! You are not finished yet
In order to complete this process, this form MUST be
1) Printed
2) Signed by all parties
3) Retained by the Agency with all original signatures
4) Made available for inspection by OWCP/DFEC, if and when necessary.
Although the signed copies of such forms are physically maintained by the Employing Agency, they remain covered by the government-wide Privacy Act system of records entitled DOL/GOVT-1.
Continue to Review this Form
Done


ECOMP Claim for Compensation (CA-7)
Case 252169726 | ECN 2584992
CA-7
Pending review by FECA Agency Reviewer
Step 1
Claim Summary
Claimant: SMITH, TOM
DOB: 05/01/1965
SSN: *****3333
Address: 123 E ST
WASHINGTON , DC 20210
ECN 2584992
Date of event 02/01/2016
Filed 05/25/2016
Agency OWCP TEST ONLY
Click to attach a new document
There are currently 0 attachments for this form.
Attach New Document...
Delete selected attachment
Have Questions?
View Frequently Asked Questions.
Continue

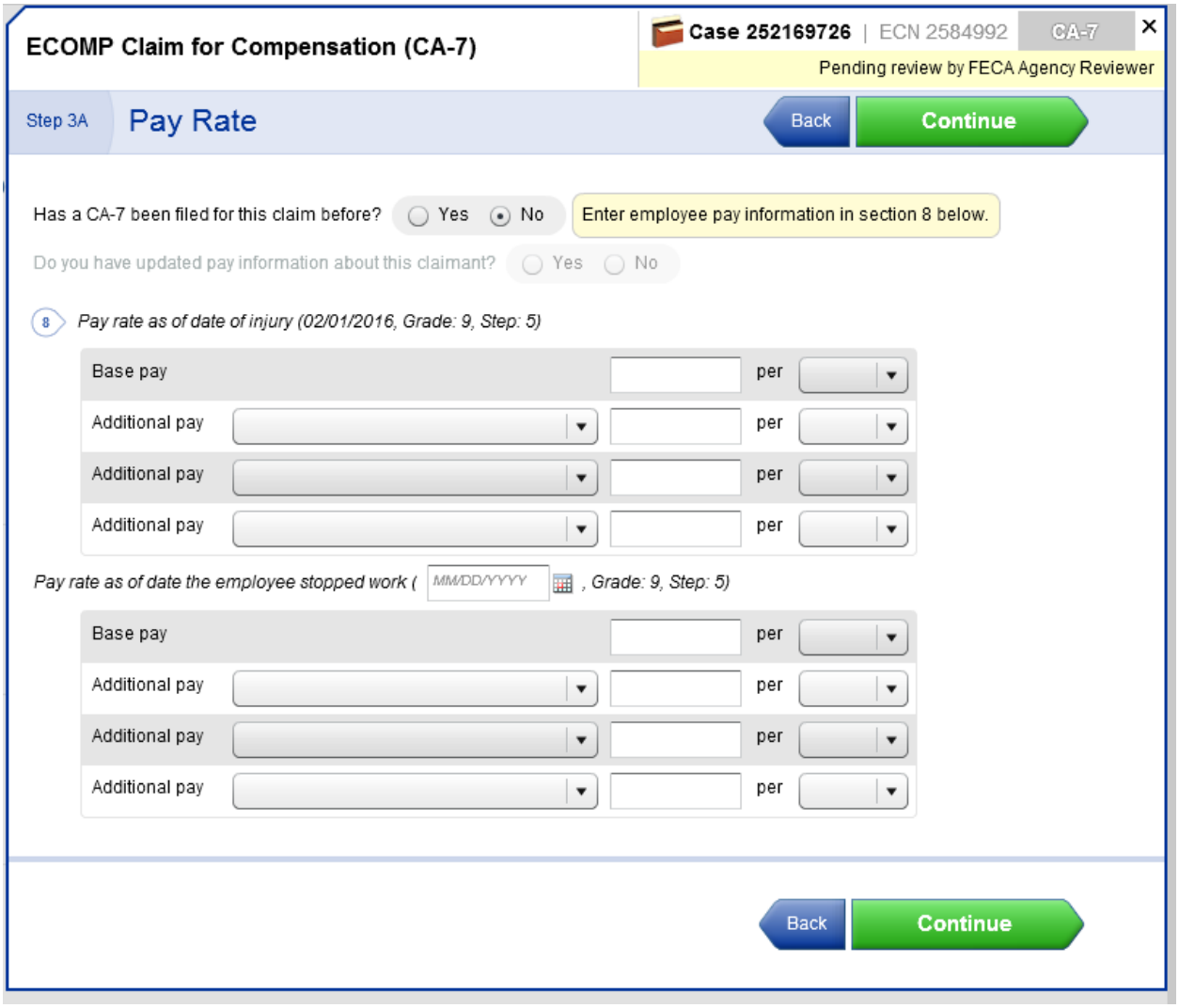
ECOMP Claim for Compensation (CA-7)

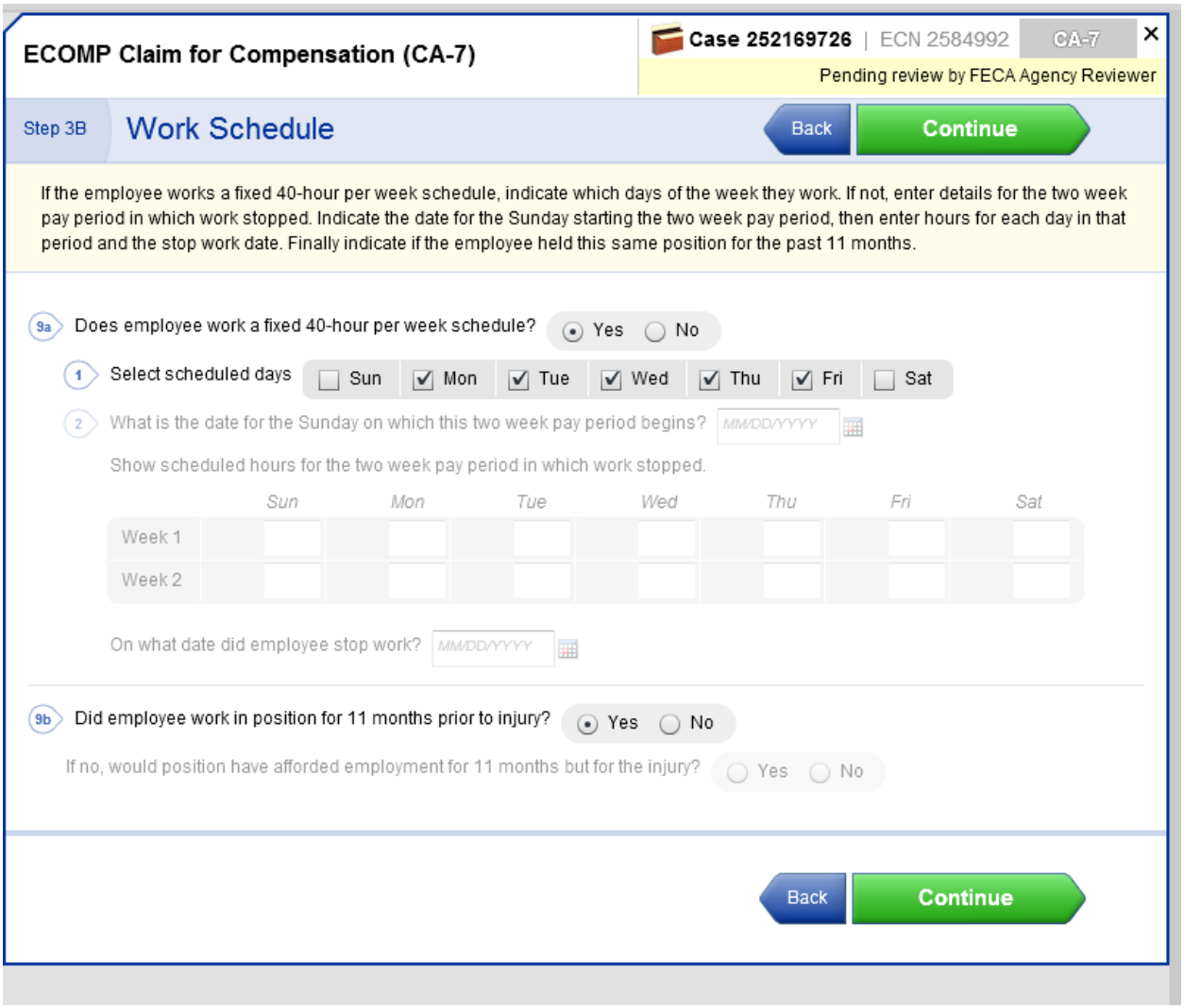
Case 252169726 | ECN 2584992 CA-7

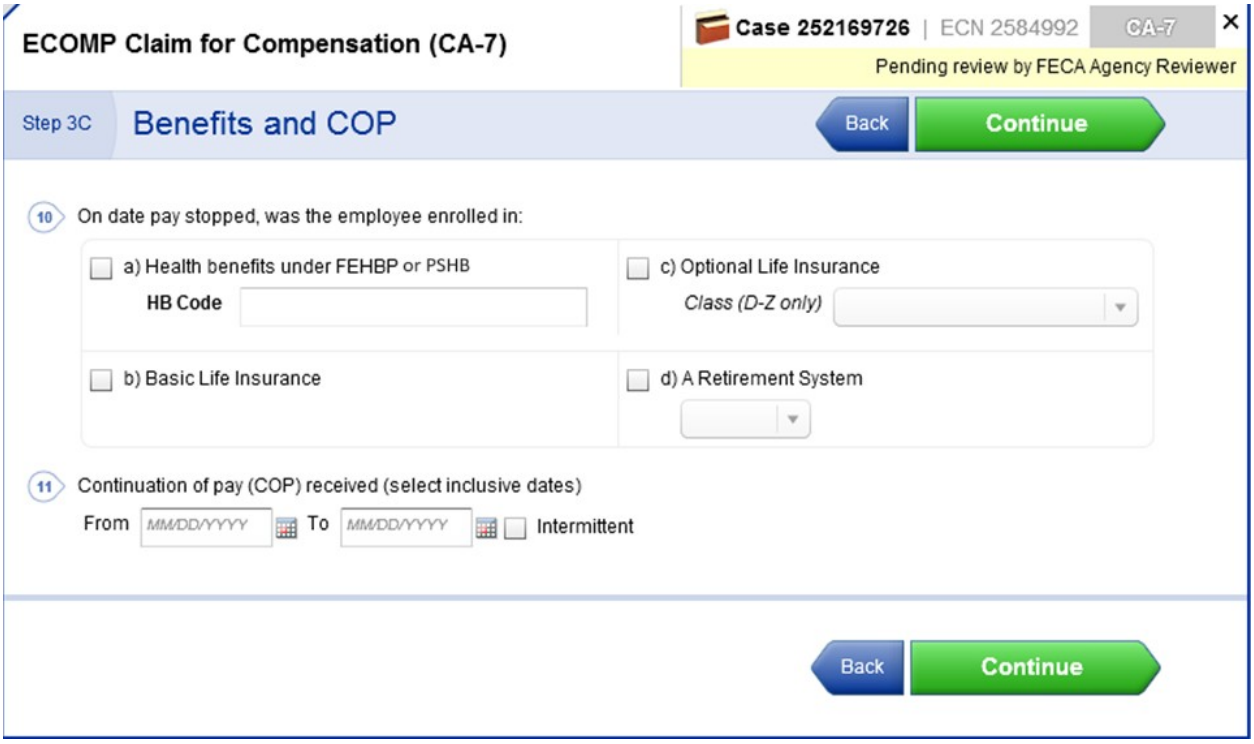
Pending review by FECA Agency Reviewer

Step 2 **Review CA-7 Claimant Part** Back Continue

Employee name (first, middle, last)	TOM SMITH
Government organization	XX ECOMP TEST (DO NOT USE) OWCP TEST ONLY C/O ECOMP -TA TEST 203 UNION STREET WASHINGTON, DC 20210
Reviewer	Agency Reviewer
Home mailing address	123 E ST WASHINGTON DC 20210
OWCP File Number	252169726
Date of injury	02/01/2016
Social security number	*****3333
Home telephone	2025551234
Compensation claimed	Leave without pay 05/01/2016 *To* 05/10/2016
Non-federal employment?	No
First-time claim?	No
Changes to dependents?	Yes
Dependent #1	SO Lives with claimant.
Dependent #2	
Are you making support payments for a dependent shown above?	No
Third party claim	No, there will not be a claim made against a 3rd party.
VA disability benefits	No, I have not applied for nor received benefits from the Department of Veterans Affairs. *Claim #* */month*


ECOMP Claim for Compensation (CA-7)
Case 252169726 | ECN 2584992
CA-7
Pending review by FECA Agency Reviewer
Step 3A
Pay Rate
Back
Continue
Has a CA-7 been filed for this claim before?
Yes
No
Enter employee pay information in section 8 below.
Do you have updated pay information about this claimant?
Yes
No
8
Pay rate as of date of injury (02/01/2016, Grade: 9, Step: 5)
Base pay
per
Additional pay
per
Additional pay
per
Additional pay
per
Pay rate as of date the employee stopped work (
MM/DD/YYYY
, Grade: 9, Step: 5)
Base pay
per
Additional pay
per
Additional pay
per
Additional pay
per
Back
Continue


ECOMP Claim for Compensation (CA-7)
Case 252169726 | ECN 2584992
CA-7
Pending review by FECA Agency Reviewer
Step 3B
Work Schedule
Back
Continue
If the employee works a fixed 40-hour per week schedule, indicate which days of the week they work. If not, enter details for the two week pay period in which work stopped. Indicate the date for the Sunday starting the two week pay period, then enter hours for each day in that period and the stop work date. Finally indicate if the employee held this same position for the past 11 months.
9a
Does employee work a fixed 40-hour per week schedule?
Yes
No
1
Select scheduled days
Sun
Mon
Tue
Wed
Thu
Fri
Sat
2
What is the date for the Sunday on which this two week pay period begins?
MM/DD/YYYY
Show scheduled hours for the two week pay period in which work stopped.
Sun
Mon
Tue
Wed
Thu
Fri
Sat
Week 1
Week 2
On what date did employee stop work?
MM/DD/YYYY
9b
Did employee work in position for 11 months prior to injury?
Yes
No
If no, would position have afforded employment for 11 months but for the injury?
Yes
No
Back
Continue


ECOMP Claim for Compensation (CA-7)
Case 252169726 | ECN 2584992
CA-7
Pending review by FECA Agency Reviewer
Step 3C
Benefits and COP
Back
Continue
10
On date pay stopped, was the employee enrolled in:
a) Health benefits under FEHBP or PSHB
HB Code
c) Optional Life Insurance
Class (D-Z only)
b) Basic Life Insurance
d) A Retirement System
11
Continuation of pay (COP) received (select inclusive dates)
From
MM/DD/YYYY
To
MM/DD/YYYY
Intermittent
Back
Continue

ECOMP Claim for Compensation (CA-7)

Case 252169726 | ECN 2584992 CA-7 ×

Pending review by FECA Agency Reviewer

Step 3D **Pay, Return to Work** Back Continue

12 Show pay status inclusive dates for the period(s) claimed

Sick leave	From	MM/DD/YYYY	To	MM/DD/YYYY	Intermittent
Annual leave	From	MM/DD/YYYY	To	MM/DD/YYYY	Intermittent
Leave without pay (LWOP)	From	MM/DD/YYYY	To	MM/DD/YYYY	Intermittent
Work	From	MM/DD/YYYY	To	MM/DD/YYYY	Intermittent

13 Did employee return to work? ◯ Yes ◯ No

What date did he/she return to work? MM/DD/YYYY

If returned to work, did employee return to the pre-date-of-injury job, with the same hours and the same duties?

◯ Yes ◯ No

14 Remarks

15 Agency official name First name Middle name Last name

Agency official title Agency Reviewer

Date Claim Form Received from Employee *05/25/2016*

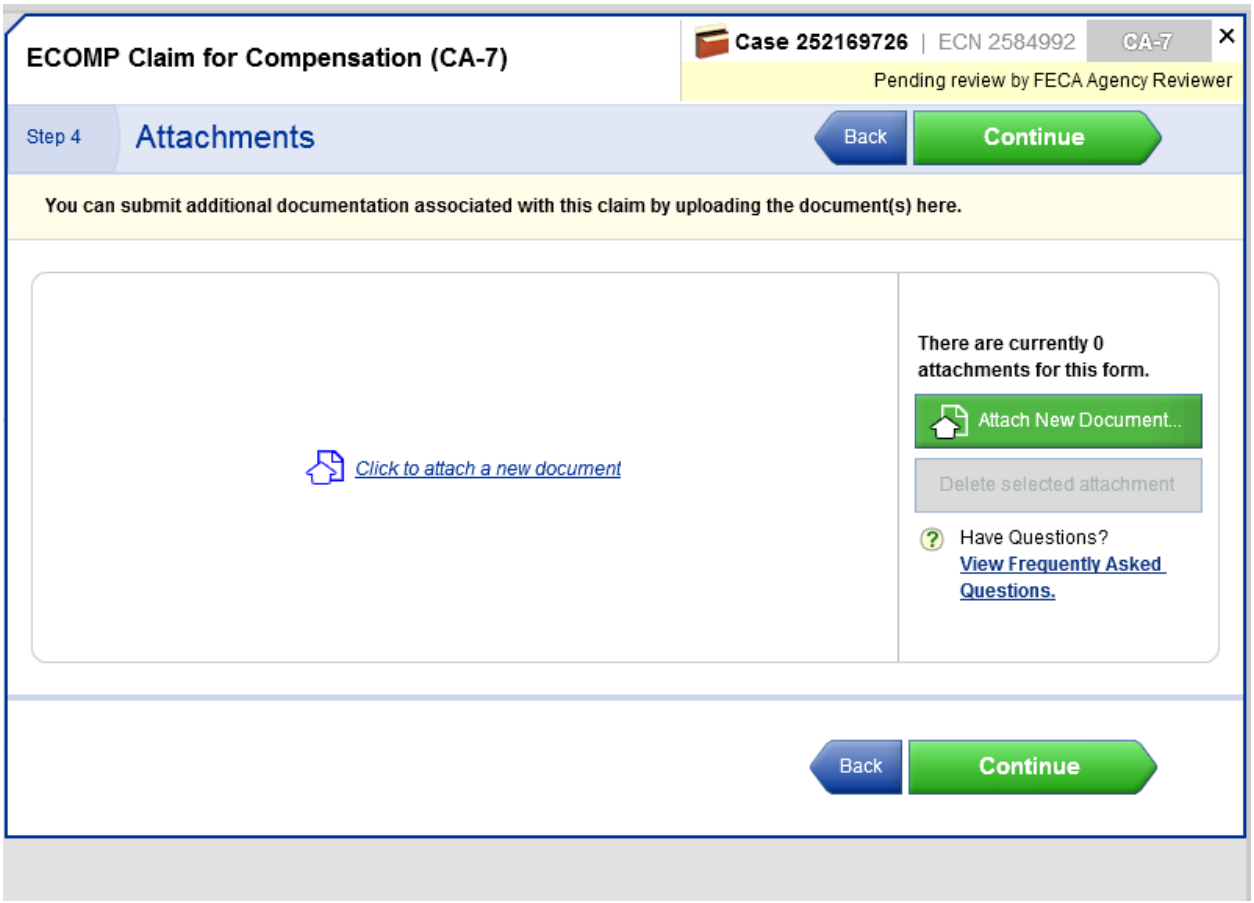
Name of Agency
C/O ECOMP -TA TEST
OWCP TEST ONLY
ECOMP Testing Only (DO NOT USE)
XX ECOMP TEST (DO NOT USE)

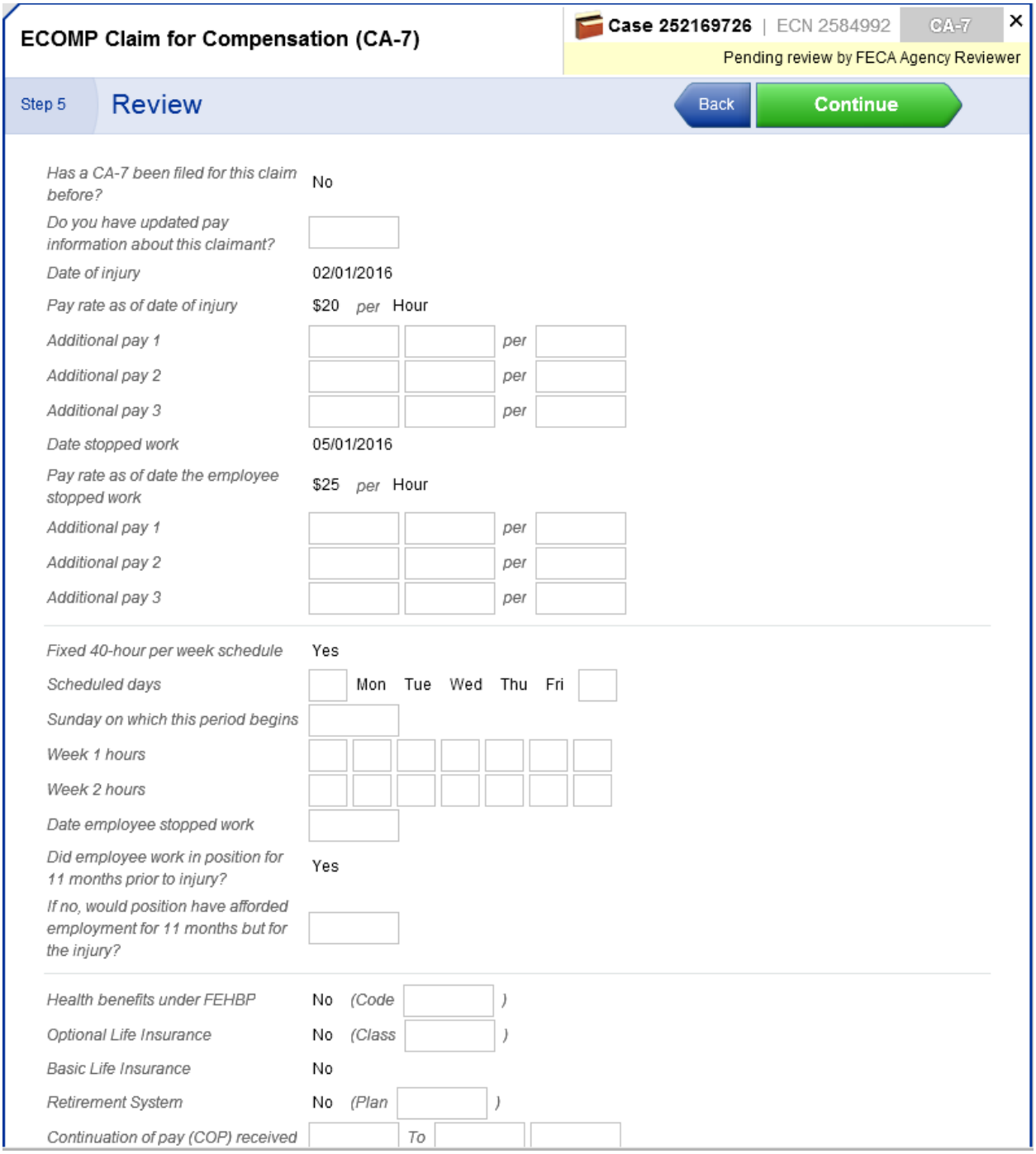
If OWCP needs specific pay information, the person who should be contacted is

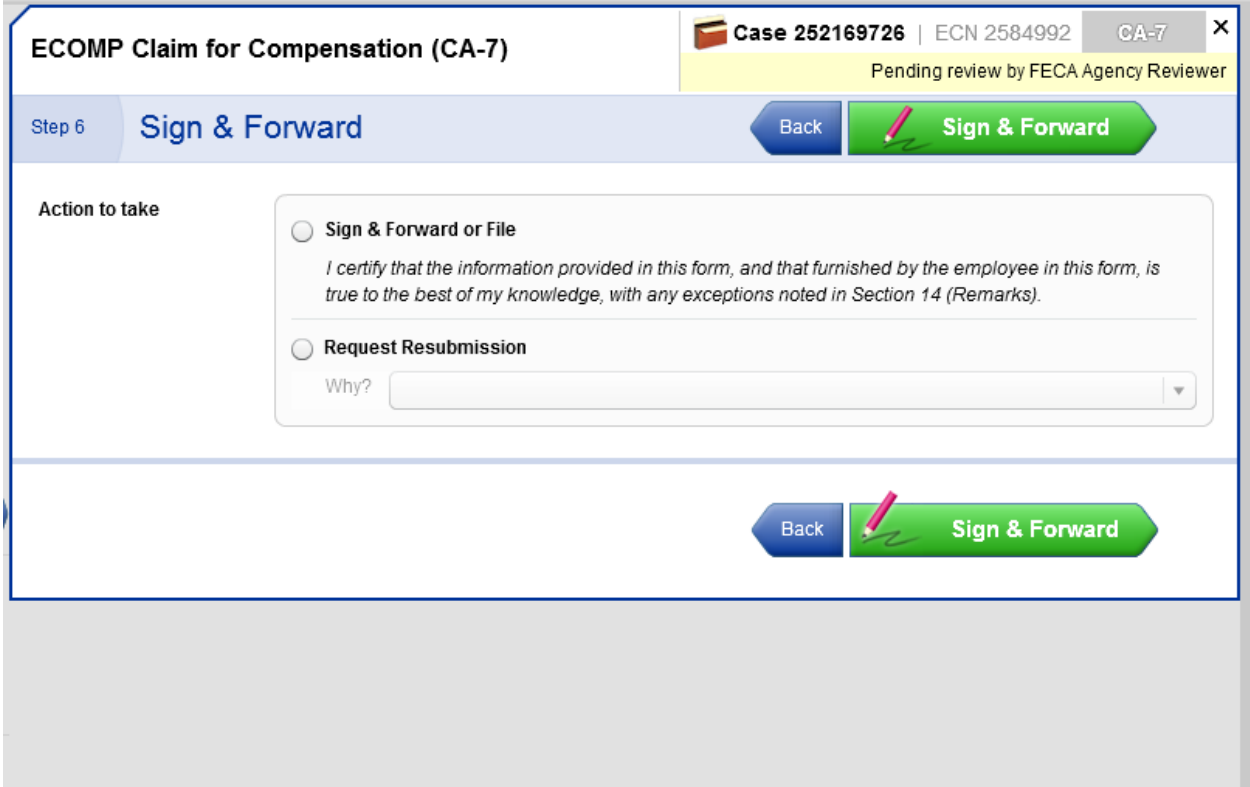
Name First name Middle name Last name

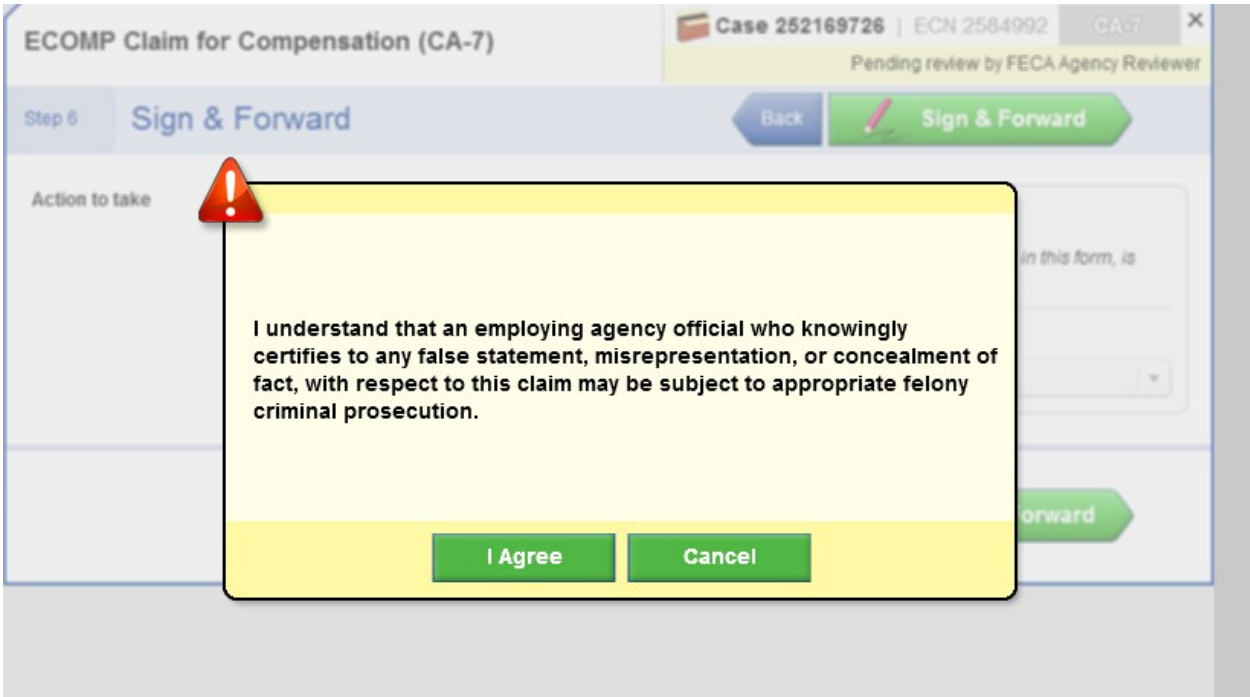
Email Title

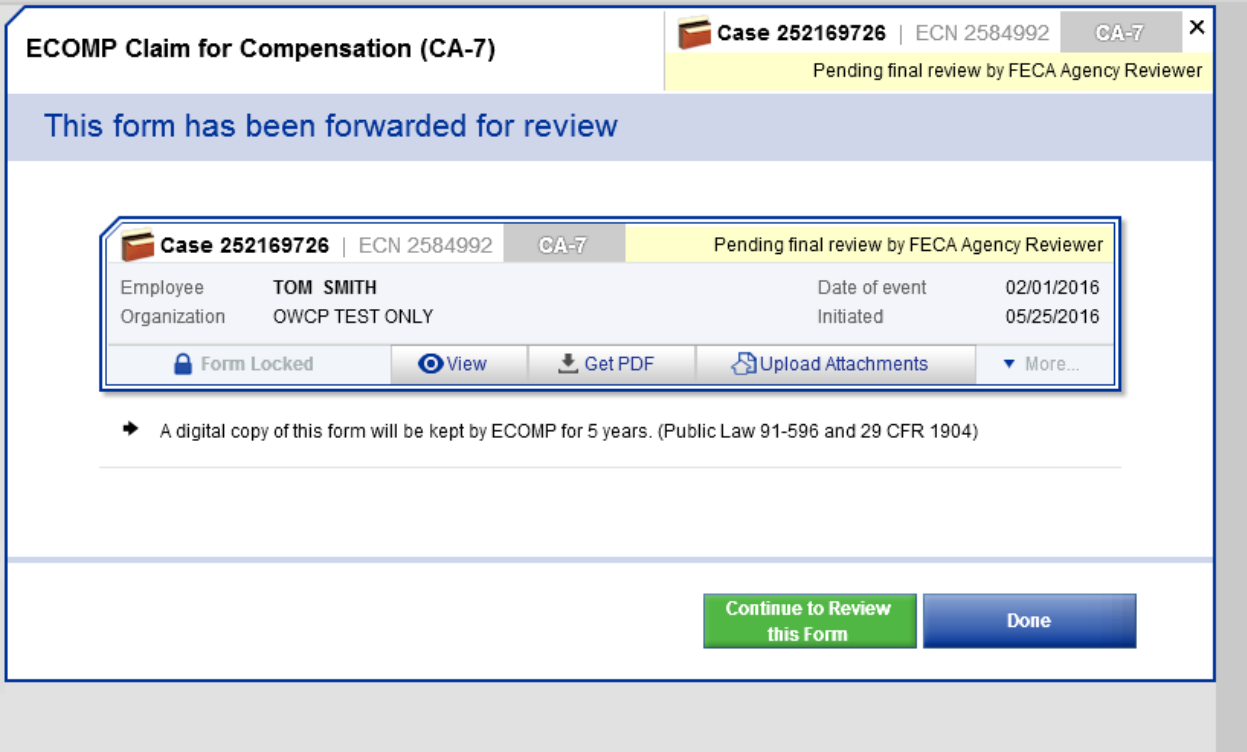
Telephone (XXX) XXX-XXXX ☐ International Fax (XXX) XXX-XXXX ☐ International


ECOMP Claim for Compensation (CA-7)
Case 252169726 | ECN 2584992
CA-7
Pending review by FECA Agency Reviewer
Step 4
Attachments
Back
Continue
You can submit additional documentation associated with this claim by uploading the document(s) here.
Click to attach a new document
There are currently 0 attachments for this form.
Attach New Document...
Delete selected attachment
Have Questions?
View Frequently Asked Questions.
Back
Continue


ECOMP Claim for Compensation (CA-7)
Case 252169726 | ECN 2584992 CA-7
Pending review by FECA Agency Reviewer
Step 5
Review
Back
Continue
Has a CA-7 been filed for this claim before?
No
Do you have updated pay information about this claimant?
Date of injury
02/01/2016
Pay rate as of date of injury
$20 per Hour
Additional pay 1
per
Additional pay 2
per
Additional pay 3
per
Date stopped work
05/01/2016
Pay rate as of date the employee stopped work
$25 per Hour
Additional pay 1
per
Additional pay 2
per
Additional pay 3
per
Fixed 40-hour per week schedule
Yes
Scheduled days
Mon Tue Wed Thu Fri
Sunday on which this period begins
Week 1 hours
Week 2 hours
Date employee stopped work
Did employee work in position for 11 months prior to injury?
Yes
If no, would position have afforded employment for 11 months but for the injury?
Health benefits under FEHBP
No (Code)
Optional Life Insurance
No (Class)
Basic Life Insurance
No
Retirement System
No (Plan)
Continuation of pay (COP) received
To


ECOMP Claim for Compensation (CA-7)
Case 252169726 | ECN 2584992
CA-7
Pending review by FECA Agency Reviewer
Step 6
Sign & Forward
Back
Sign & Forward
Action to take
Sign & Forward or File
I certify that the information provided in this form, and that furnished by the employee in this form, is true to the best of my knowledge, with any exceptions noted in Section 14 (Remarks).
Request Resubmission
Why?
Back
Sign & Forward


ECOMP Claim for Compensation (CA-7)
Case 252169726 | ECN 2584992
Pending review by FECA Agency Reviewer
Step 6
Sign & Forward
Back
Sign & Forward
Action to take
I understand that an employing agency official who knowingly certifies to any false statement, misrepresentation, or concealment of fact, with respect to this claim may be subject to appropriate felony criminal prosecution.
I Agree
Cancel


ECOMP Claim for Compensation (CA-7)
Case 252169726 | ECN 2584992 CA-7
Pending final review by FECA Agency Reviewer
This form has been forwarded for review
Case 252169726 | ECN 2584992 CA-7
Pending final review by FECA Agency Reviewer
Employee TOM SMITH
Organization OWCP TEST ONLY
Date of event 02/01/2016
Initiated 05/25/2016
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A digital copy of this form will be kept by ECOMP for 5 years. (Public Law 91-596 and 29 CFR 1904)
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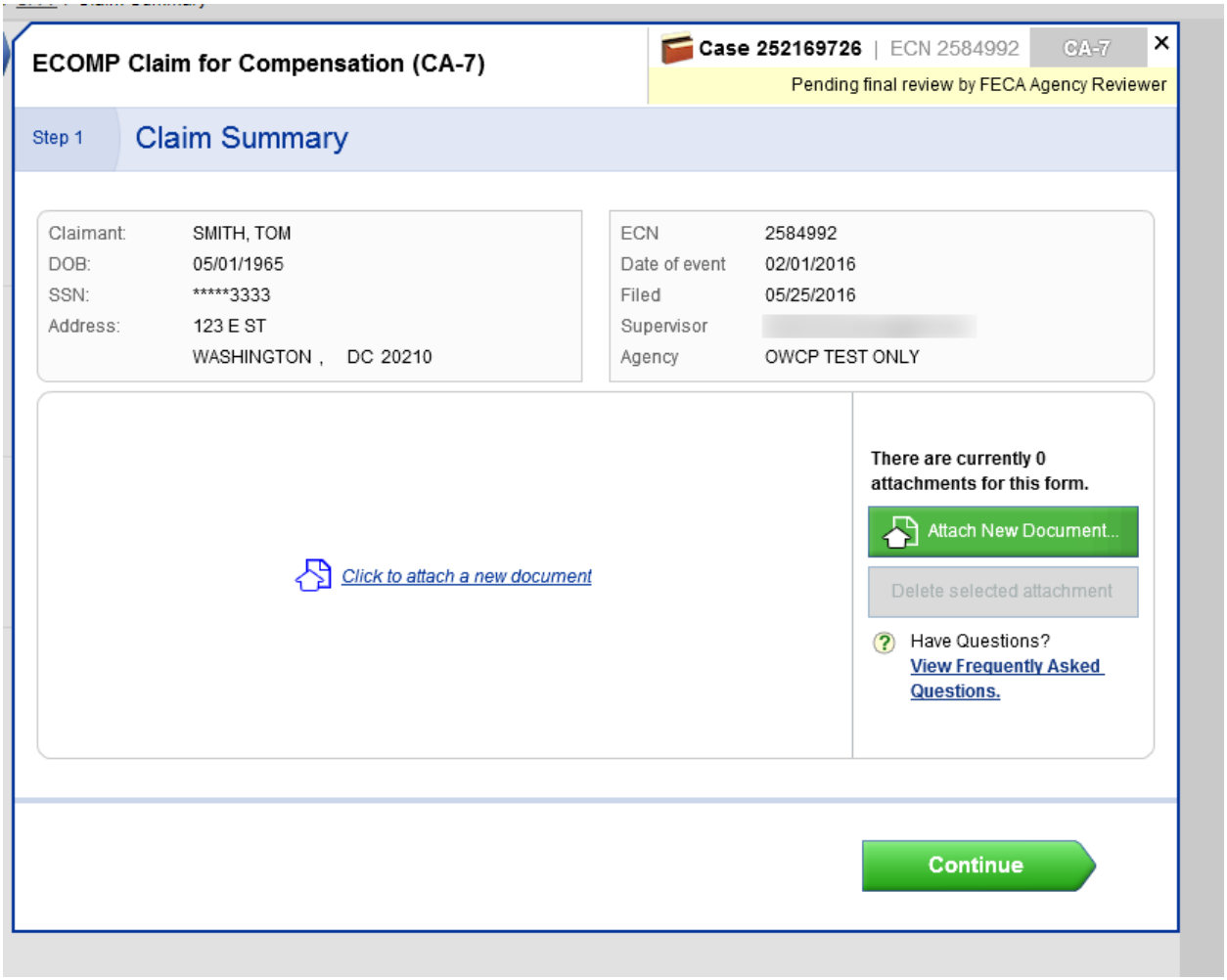
ECOMP Claim for Compensation (CA-7)
Case 252169726 | ECN 2584992
CA-7
Pending final review by FECA Agency Reviewer
Step 1
Claim Summary
Claimant: SMITH, TOM
DOB: 05/01/1965
SSN: *****3333
Address: 123 E ST
WASHINGTON , DC 20210
ECN 2584992
Date of event 02/01/2016
Filed 05/25/2016
Supervisor
Agency OWCP TEST ONLY
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Have Questions?
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Continue

ECOMP Claim for Compensation (CA-7)

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Step 2A **Claimant Portion**

Back | Continue

Employee name (first, middle, last)	TOM SMITH
Government organization	XX ECOMP TEST (DO NOT USE) OWCP TEST ONLY C/O ECOMP -TA TEST 203 UNION STREET WASHINGTON, DC 20210
Reviewer	Agency Reviewer
Home mailing address	123 E ST WASHINGTON DC 20210
OWCP File Number	252169726
Date of injury	02/01/2016
Social security number	*****3333
Home telephone	2025551234
Compensation claimed	Leave without pay 05/01/2016 *To* 05/10/2016
Non-federal employment?	No
First-time claim?	No
Changes to dependents?	Yes
Dependent #1	SO Lives with claimant.
Dependent #2	
Are you making support payments for a dependent shown above?	No
Third party claim	No, there will not be a claim made against a 3rd party.
VA disability benefits	No, I have not applied for nor received benefits from the Department of Veterans Affairs. *Claim #*

ECOMP Claim for Compensation (CA-7)

Case 252169726 | ECN 2584992 CA-7 ×

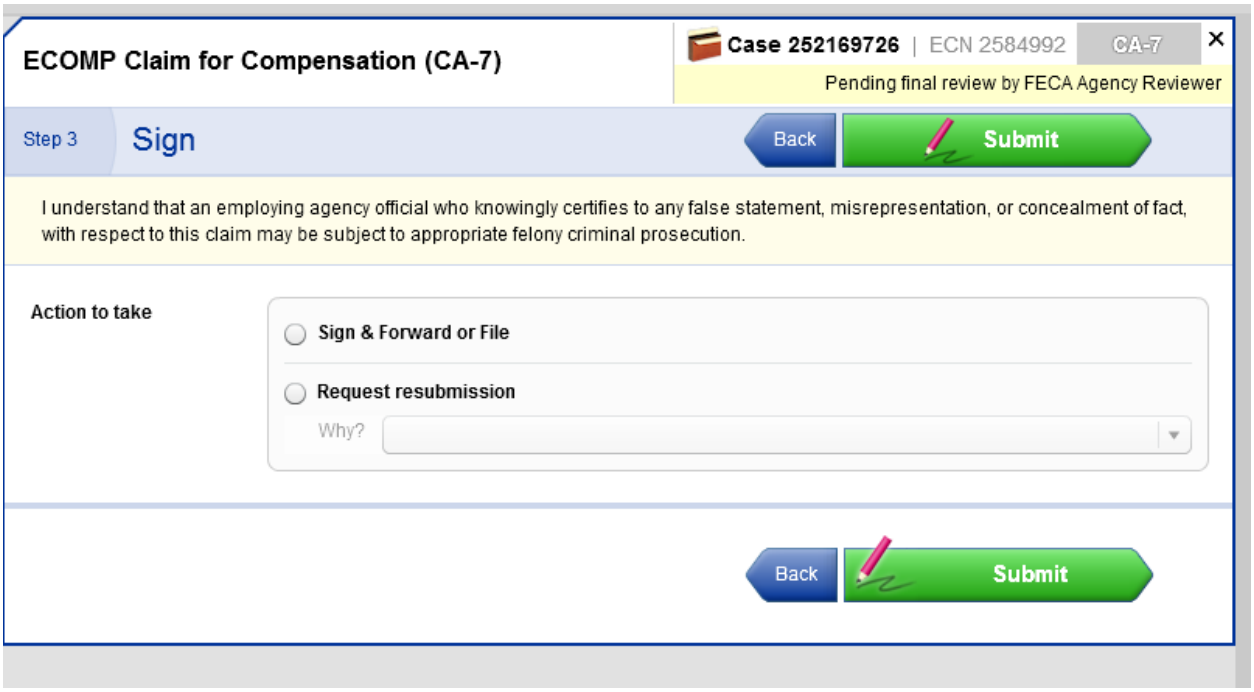
Pending final review by FECA Agency Reviewer

Step 2B **Supervisor Portion** Back Continue

Has a CA-7 been filed for this claim before?	No
Do you have updated pay information about this claimant?	
Date of injury	02/01/2016
Pay rate as of date of injury	$20 *per* Hour
Additional pay 1	*per*
Additional pay 2	*per*
Additional pay 3	*per*
Date stopped work	05/01/2016
Pay rate as of date the employee stopped work	$25 *per* Hour
Additional pay 1	*per*
Additional pay 2	*per*
Additional pay 3	*per*

Fixed 40-hour per week schedule	Yes
Scheduled days	Mon Tue Wed Thu Fri
Sunday on which this period begins	
Week 1 hours	
Week 2 hours	
Date employee stopped work	
Did employee work in position for 11 months prior to injury?	Yes
If no, would position have afforded employment for 11 months but for the injury?	

Health benefits under FEHBP	No *(Code)*
Optional Life Insurance	No *(Class)*
Basic Life Insurance	No
Retirement System	No *(Plan)*
Continuation of pay (COP) received	*To*


ECOMP Claim for Compensation (CA-7)
Case 252169726 | ECN 2584992
CA-7
Pending final review by FECA Agency Reviewer
Step 3
Sign
Back
Submit
I understand that an employing agency official who knowingly certifies to any false statement, misrepresentation, or concealment of fact, with respect to this claim may be subject to appropriate felony criminal prosecution.
Action to take
Sign & Forward or File
Request resubmission
Why?
Back
Submit


ECOMP Claim for Compensation (CA-7)
Case 252169726 | ECN 2584992 CA-7
Submitted to DFEC
This form has been submitted to DFEC
Case 252169726 | ECN 2584992 CA-7
Submitted to DFEC
Employee TOM SMITH
Organization OWCP TEST ONLY
Date of event 02/01/2016
Initiated 05/25/2016
Form Locked
View
Get PDF
Upload Attachments
More...
Wait! You are not finished yet
In order to complete this process, this form MUST be
1) Printed
2) Signed by all parties
3) Retained by the Agency with all original signatures
4) Made available for inspection by OWCP/DFEC, if and when necessary.
Although the signed copies of such forms are physically maintained by the Employing Agency, they remain covered by the government-wide Privacy Act system of records entitled DOL/GOVT-1.
I Agree. Get PDF and Save / Print
Done