Claim for Compensation

Reset Print

U.S. Department of Labor

Office of Workers' Compensation Programs

SECTION 1 **EMPLOYEE PORTION**

a. Name of Employee Last First Middle

OMB No. 1240-0046
Expires: 08/31/2026

b. Mailing Address (*Including City State, ZIP Code*)

c. OWCP File Number

E-Mail Address *(Optional)*

d. Date of Injury Month Day Year

e. Social Security Number

f. Telephone No./FAX No.

SECTION 2 Compensation is claimed for:

		Inclusive Date Range From	To	Intermittent?	
a.	☐ Leave without pay			☐ Yes ☐ No	*Go to Section 3*
b.	☐ Leave buy back			☐ Yes ☐ No	*Go to Section 3, and Complete Form CA-7b*
c.	☐ Other wage loss; specify type, such as downgrade, loss of night differential, etc. Type:			☐ Yes ☐ No	*Go to Section 3*
d.	☐ Schedule Award *(Go to Section 4)*			If intermittent, complete Form CA-7a, Time Analysis Sheet	

SECTION 3 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.***

☐ Yes

Name and Address of Business:

Name Address City State ZIP Code

☐ No
Go to section 4

Dates Worked: Type of Work:

SECTION 4 Is this the first CA-7 claim for compensation you have filed for this injury?

☐ Yes *Complete Sections 5 through 7 and a Form SF-1199A, "Direct Deposit Sign-up"*

☐ No If changes to dependent status, direct deposit information, or if a claim has been filed with the U.S. Civil Service Retirement, another federal retirement/disability law, or with Department of Veteran Affairs, complete Sections 5 through 7 or a new SF-1199A. If no, complete Section 7.

☐ Yes - *Complete Sections 5 through 7 or a new SF-1199A to reflect change(s)* ☐ No - *Complete Section 7*

SECTION 5 List your dependents (including spouse). If additional space is necessary, provide same information requested below on separate page(s) and include your name/claim number at the top of the page(s).

Name	Social Security #	Date of Birth	Relationship	Living with you? Yes	No
				☐	☐
				☐	☐

For dependents not living with you complete items a and b below. ,

a. Are you making support payments for a dependent noted above or on your attachment(s)? ☐ Yes ☐ No If Yes, support payments are made to:

Name Address City State ZIP Code

b. Were support payments ordered by a court? ☐ Yes ☐ No If Yes, attach copy of court order.

SECTION 6 a. Was/Will there be a claim made against a 3rd party? ☐ Yes ☐ No

b. Have you ever applied for or received disability benefits from the Department of Veterans Affairs?

	Claim Number	Full Address of VA Office Where Claim Filed	Nature of Disability and Monthly Payment
☐ Yes ☐ No			

c. Have you applied for or received payment under any Federal Retirement or Disability law?

	Claim Number	Date Annuity Began	Amount of Monthly Payment	Retirement System (CSRS, FERS, SSA, Other)
☐ Yes ☐ No				☐ CSRS ☐ FERS ☐ SSA ☐ Other

SECTION 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. 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 criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both. In addition, a state or federal criminal conviction for FECA fraud 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.

Employee's Signature _____ Date (*Mo., day, year*) _____

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodations and/or modifications, please contact OWCP. See form instructions for Requests for Accommodations or Auxiliary Aids and Services.

Employing Agency Portion
For first CA-7 claim sent, complete sections 8 through 15.
For subsequent claims, complete sections 12 through 15 only.

SECTION 8 Show Pay Rate as of

Date of Injury: Base Pay
Date: _____ $ _____ per _____
Grade: _____ step: _____

Additional Pay: Type _____ $ _____ per _____
Additional Pay: Type _____ $ _____ per _____
Additional Pay: Type _____ $ _____ per _____

Date Employee Stopped Work:
Date: _____ $ _____ per _____
Grade: _____ step: _____

Additional Pay: Type _____ $ _____ per _____
Additional Pay: Type _____ $ _____ per _____
Additional Pay: Type _____ $ _____ per _____

Additional pay types include, but are not limited to: Night Differential (ND), Sunday Premium (SP), Holiday Premium (HP), Subsistence (SUB), Quarter (QTR), etc. (List each separately)

SECTION 9

a. Does employee work a fixed 40-hour per week schedule? ☐ Yes ☐ No

1. If Yes, circle scheduled days: ☐ S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S

2. If No, show scheduled hours for the two week pay period in which work stopped. Circle the day that work stopped.

FOR EXAMPLE ONLY

	S	M	T	W	TH	F	S
WEEK 1 From 5/14 to 5/20		8	4	6	(6)		
WEEK From 5/21 to 5/27		8		6	6		4

	S	M	T	W	TH	F	S
From _____ To _____							
From _____ To _____							

b. 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

SECTION 10 On date pay stopped, was employee enrolled in:

a. Health Benefits under the FEHBP or PSHB? ☐ No ☐ Yes Code _____

b. Basic Life Insurance? ☐ No ☐ Yes

c. Optional Life Insurance? ☐ No ☐ Yes Class _____ *(D-Z only)*

d. A Retirement System? ☐ No ☐ Yes Plan _____ *(Specify CSRS, FERS, Other)*

SECTION 11 Continuation of Pay (COP) Received (*Show inclusive dates*):

From _____ To _____

Intermittent? ☐ Yes - Complete Time Analysis Sheet, Form CA-7a ☐ No

SECTION 12 Show pay status and inclusive dates for period(s) claimed:

			Intermittent?	
Sick Leave From	_____	To _____	☐ Yes ☐ No	If intermittent, complete Form CA-7a, Time Analysis Sheet.
Annual Leave From	_____	To _____	☐ Yes ☐ No	
Leave without Pay From	_____	To _____	☐ Yes ☐ No	If leave buy back, also submit completed Form CA-7b.
Work From	_____	To _____	☐ Yes ☐ No	

SECTION 13 Did employee return to work? ☐ Yes ☐ No
If Yes, date _____

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

☐ Yes ☐ No If No, explain: _____

SECTION 14 Remarks: _____

SECTION 15 An employing agency official who knowingly certifies to any false statement, misrepresentation, or concealment of fact with respect to this claim (or impedes the filing of a claim) may also be subject to appropriate criminal prosecution.

I certify that the information given above and that furnished by the employee on this form is true to the best of my knowledge, with any exceptions noted in Section 14, Remarks, above.

Signature _____ Title _____ Date ___/___/___
(*Agency Official*)

Name of Agency _____

Date Claim Form Received from Employee ___/___/___

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

Name _____ Title _____

Telephone No. _____ Fax No. _____ E-Mail Address _____

INSTRUCTIONS FOR COMPLETING FORM CA-7

If additional space is needed to respond to questions on this form, attach a separate sheet of paper and write, “see attachment” in the applicable portion of the form. Please ensure the claimant's full name and claim number appear on the separate sheet(s).

If the employee does not quality for continuation of pay (for 45 days), the form should be completed and filed with the OWCP as soon as pay stops. The form should also be submitted when the employee reaches maximum improvement and claims a schedule award. If the employee is receiving continuation of pay and will continue to be disabled after 45 days, the form should be filed with OWCP 5 working days prior to the end of the 45-day period.

The CA-7 also should be used to claim continuing compensation, when a previous CA-7 claim has been made.

Collection of this information is required to obtain a benefit and is authorized by 20 C.F.R.10.102, 20 C.F.R.10.103, and 20 C.F.R.10.404.

Notice

Requests for Accommodations or Auxiliary Aids and Services

If you have a disability, federal law gives you the right to receive help from the OWCP in the form of communication assistance, accommodation(s) and/or modification(s) to aid you in the claims process. For example, we will provide you with copies of documents in alternate formats, communication services such as sign language interpretation, or other kinds of adjustments or changes to accommodate your disability. Please contact our office or your OWCP claims examiner to ask about this assistance.

EMPLOYEE (or person acting on the employee's behalf) - Complete sections 1 through 7 as directed and submit the form to the employee's supervisor.

SUPERVISOR (or appropriate official in the employing agency) - Complete sections 8 through 15 as directed and promptly forward the form to the OWCP.

EXPLANATIONS - Some of the items on the form which may require further clarification are explained below:

Section Number	Explanation
2d. Schedule Award	Schedule awards are paid for permanent impairment to a member or function of the body.
3. Employment	An employee who either claims or is receiving compensation for partial or total disability must advise OWCP immediately of any return to work. An employee must report **all** outside employment, including any concurrent dissimilar employment held at the time of injury. The employee must report even those earnings which do not seem likely to affect benefits; failure to report earnings may result in forfeiture of **all** benefits paid during the period for which compensation is claimed. For example, include sales, farming, and operating (or keeping books for) a business including a family business. Report providing services (such as carpentry, mechanical work, child care, odd jobs) provided in exchange for money, goods, or other services. Report part-time or intermittent activities and any volunteer work for which any form of monetary or in-kind compensation was received. Passive investment in any public traded business is not a required reporting item.
4. Direct Deposit Information	The Department of the Treasury requires all Federal payments be made by electronic funds transfer (EFT), also called Direct Deposit. If you have not previously signed up to receive compensation with EFT, or desire to change your current account information, please submit SF-1199A, Direct Deposit Sign Up. If you do not have a bank account, you may be required to receive your payment through Direct Express Debit MasterCard. To request information on the Direct Express Debit MasterCard, go to www.usdirectexpress.com or call 1-800-333-1795. If directed to enroll in the Program, you may contact the Department of the Treasury at 1-888-224-2950 to address any questions or concerns you may have, as well as apply for a waiver from the process. NOTE: payments to residents of foreign countries are exempt from the Treasury requirements.
5. List your dependents	Your spouse is a dependent if he or she is living with you. A child is a dependent if he, or she either lives with you or receives support payments from you, and he or she: 1) is under 18, or 2) is between 18 and 23 and is a full-time student, or 3) is incapable of self-support due to physical or mental disability.
6a. Was/will there be a claim made against 3rd party?	A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer who gave improper instructions for the use of a chemical to which an employee is exposed, could all be considered third parties to the injury.
8. Additional Pay	"Additional Pay" includes night differential, Sunday premium, holiday premium, and any other type (such as hazardous duty or "dirty work" pay) regularly received by the employee, but does not include pay for overtime. If the amount of such pay varies from pay period to pay period (as in the case of holiday premium or a rotating shift), then the total amount of such pay earned during the year immediately prior to the date of injury or the date the employee stopped work (whichever is greater) should be reported.
11. Continuation of pay (COP) received	If the injury was not a traumatic injury reported on Form CA-1, this item does not apply.
14. Remarks	This space is used to provide relevant information which is not present elsewhere on the form.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

The authority for requesting this information is 5 U.S.C. 8101 et seq. The information will be used to determine entitlement to benefits. Furnishing the requested information is required for the claimant to obtain or retain a benefit. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974, as amended (5 U.S.C.552a). Failure to furnish the requested information may delay the process, or result in an unfavorable decision or a reduced benefit.

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 13 minutes per response, including time for reviewing instructions, searching existing data sources, gathering the data needed, and completing and reviewing the collection of information. The obligation to respond to this collection is voluntary (5 U.S.C. 8101 et seq.) to obtain or retain a benefit. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S3229, 200 Constitution Avenue, N.W.,Washington, D.C. 20210, and reference the OMB Control Number 1240-0046. Note: Do not submit the completed claim form to this address.

Privacy Act

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) is administered by the Office of Workers' Compensation Programs of the U. S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to retention, rehire, or other relevant matters. (4) Information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other healthcare providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection Act. (7) Disclosure of the claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, to verify earnings without further written authorization, and for other purposes required or authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

Note: This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the FECA.