

# Application for Special Fund Relief

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



INSTRUCTIONS: You must use this form to request Special Fund relief under Section 8(f) of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 908(f), and extensions. You must attach supporting documentation as described in 20 CFR 702.321(a) and file the application within the time limits set forth in 20 CFR 702.321(b).

OMB No.: 1240-0058  
Expires: 03/31/2026

Submit form to the OWCP/DLHWC Central Mail Receipt site at the following address:  
U.S. Department of Labor, Office of Workers' Compensation Programs  
DLHWC  
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/>

**If you have not already filed a service waiver, you should promptly submit an LS-801 or LS-802 form(s) to receive the Order via email. The form(s) must be uploaded in SEAPortal separately.**

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|--|------------------|-------------|
| 1. Date of Accident/Illness:   | 2. Carrier's No. | 3. OWCP No. |
| 4. Name of Injured Worker <u>and</u> Claimant <i>if other than injured worker</i>  |                  |             |
| 5. Explain how limitation of liability under Section 8(f) would apply to this injury.  |                  |             |
| 6. Describe the nature of the injury, and disability/death:  |                  |             |
| 7. List documentation to show extent of disability and date of maximum medical improvement, if applicable:   |                  |             |
| 8. List documentation of pre-existing disability(ies) manifest to employer:  |                  |             |
| 9. List evidence that explains how injury is not the sole cause of disability/death, and if permanent partial disability, how disability is substantially greater as a result of the manifested pre-existing disability(ies) listed above: |                  |             |
| 10. List any pending issues/disputes:  |                  |             |
| 11. 8(f) Relief is sought for: <input type="checkbox"/> Permanent Total Disability (PTD) <input type="checkbox"/> Permanent Partial Disability (PPD) - Hearing Loss<br><input type="checkbox"/> Permanent Partial Disability (PPD)         |                  |             |
| 12. If PPD, list documentation establishing injured workers' earning capacity:   |                  |             |

Do **NOT** attach or submit irrelevant records.

## 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 Special Fund Relief by the Office of Workers' Compensation Longshore Program under 33 U.S.C. 908(f) and 20 C.F.R. 702.321. 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-5 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 if Special Fund Relief will be granted under the LHWCA. (3) Completion of this form is required to request Special Fund relief 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 Special Fund application or result in the denial of Special Fund relief. (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.