



Notice of Injury or Disease and Claim for Benefits under the War
Hazards Compensation Act

OMB Control No. 1240-0006
Expiration Date: XX/XX/XXXX

Provide all information requested below. Read the instructions on the reverse of this form about submitting all required documentation. Failure to furnish the requested information will result in denial of the claim for reimbursement.

Injured Employee Information:			
1. Employee's Last Name	2. Employee's First Name	3. Employee's Middle Initial	4. Employee's Date of Birth
5. Employee's Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	6. Employee's Social Security Number	<input type="checkbox"/> Non-US Resident/Citizen SSN Does Not Exist	
7. Employee's Occupation	8. Law Firm of Employee's Attorney (if applicable):		
9. Employee's US Address Line 1: Line 2: City: State: Zip:	Non-US Address (If Applicable) Line 1: Line 2: Country: City/Region:	10. Employee's Phone Number(s) Home: Cell: International:	
11. Beneficiary's Name (if death claim):			
Employer/Carrier Information:			
12. Employer Name	13. Carrier/Self Insurer Name	14. Carrier/Self Insurer NAIC/Tax ID Number	
15. Carrier Address Line 1: Line 2: City: State: Zip:			
Injury Information:			
16. Claim Type <input type="checkbox"/> Injury <input type="checkbox"/> Death	17. Date of Injury	18. Country Where Injury Occurred	
19. Description of Incident/Injury			
20. Claimed Conditions: Please Include ICD Codes if Known			
Anatomical Location of Injury	Nature of Injury	Claimed Condition	ICD (If known)

If you have a disability and need communication assistance (such as alternate formats or sign language interpretation), accommodations and/or modifications, please contact OWCP. See instructions for additional details.

Tracking Information:			
21. Longshore/DBA File Number	22. Carrier Reference Number	23. Attorney File Number	24. Insurance Policy Number
25. Insurance Policy Coverage Dates			
From:			
To:			
Submitted By and Certification			
26. Claim is hereby made by <i>(name and address of insurance carrier or self-insured or Carrier Law Firm Name)</i>			
Name: (First, Last)		Address:	
<p>The carrier certifies that no additional premium or loading was charged in this claim for a war-risk hazard as defined in 42 USC 1711(b). The insurance carrier or self-insurer agrees: (1) to abide by the rules and regulations of the Office of Workers' Compensation Programs; (2) to permit examination of the insurance records and furnish other information that may be requested by OWCP; (3) to reimburse OWCP to the extent the employee recovers damages in a third party suit; and (4) disclaims and waives any right to claim or demand, from anyone, the reimbursement of which is claimed herein and allowed by OWCP.</p> <p>I certify that the information given above is true to the best of my knowledge.</p>			
27. Carrier Attorney or Representative Name:		28. Carrier Attorney's Firm:	
		Phone Number:	
		Email Address:	
		Street Address:	
Signature of Carrier Representative, or Attorney on Behalf of Carrier		City:	State: Zip:

Instructions for Completing Form WH-1

Complete all items on the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. Some of the items on the form which may require further clarification are explained below.

19. Description of Incidence: Describe in detail how the injury or death occurred. (Relate the events which resulted in the injury or disease. Tell what the injured employee was doing at the time of the accident, what happened and how it happened. Name any objects or substances involved.)

Nature of injury: Please indicate the mechanism of injury

Anatomical Location of Injury: Please indicate all body parts involved.

20. Claimed Conditions: Please indicate all conditions diagnosed in connection with this injury and include the ICD-10 code if known.

A listing of any additional conditions, to include nature of injury and anatomical location of injury, may be attached to and submitted with this form.

Instructions for Mailing Form WH-1

1. Mail one copy of this form with the attached supporting documents described below to:

US Department of Labor - OWCP/DFEC
Attn: War Hazards
400 West Bay Street
Room 722
Jacksonville, FL 32202

2. File a separate form for each employee.

3. Complete every item on the form.

4. Attach supporting documents. The attachments should include, as applicable:

- LS-202, Employers First Report of Injury and/or
- LS-203, Employee's Claim for Compensation
- LS-208, Notice of Payments
- Compensation Order
- Section 8i Settlement Agreement (if applicable)
- Memorandum of Informal Conference (if applicable)
- Proof of Liability (policy) Covering Injury Date(s)
- Employment Agreement
- Employee/Employer Statements
- Carrier Brief/Attorney Memorandum
- Medical Evidence/Reports/Causal Relationship/Diagnosis

5. Mark each attachment with:

- (a) the case number appearing on the claim (if known)
- (b) the employee's name
- (c) "EXHIBIT" to case (such as applicable insurance policy to which attributable.

6. Attach papers in support of each case, such as copies of compensation award, any applicable contract (or sufficient excerpt), and any applicable insurance policy, marking such supporting papers as an "EXHIBIT" to the respective case.

7. Copy of the death certificate or equivalent, if applicable.

8. Copy of any available media reports or investigative reports concerning circumstances surrounding the employees' injury or death.

Note: Claims for reimbursement should be filed on the CA-278 with supporting documents attached.

War Hazards Compensation Act (WHCA)

a. The WHCA supplements the Defense Base Act (42 U.S.C. 1651), which is an extension of the Longshore and Harbor Workers' Compensation Act (LHWCA, 33 U.S.C. 901 *et seq.*) The WHCA completes the protection provided to Federal contractors' employees and certain other selected employees performing work outside the United States. All liability for injury, death and detention benefits under the WHCA is assumed by the Federal Government and is paid from the Employees' Compensation Fund established by 5 U.S.C. 8147.

b. Under Section 104 of the WHCA, an insurance carrier, self-insured employer, or compensation fund may claim reimbursement from the Employees' Compensation Fund for benefits paid on cases approved under the Defense Base Act (DBA), if it can be shown that the injury or death was due to a war-risk hazard. Where there is no compensation payable under the DBA, an employee or his or her survivors may file a claim directly under Section 101 of the WHCA. Section 101 of the WHCA also authorizes the payment of detention benefits for contractors' employees who are captured or detained by a hostile force.

Benefits for Employees Under the War Hazards Compensation Act (WHCA)

The WHCA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following benefits:

(1) Payment of compensation for disability, death, and burial expenses paid in cases accepted under Section 101 of the WHCA is computed in accordance with the benefit structure of the Longshore and Harbor Workers' Compensation Act, with the exception that the minimum limits of the LHWCA do not apply. Information necessary to compute compensation can be found in the Longshore Act whenever questions arise about the computation of benefits.

Instructions for Completing Form WH-1 Continued

(2) In addition to payments made for compensation and medical bills, insurance carriers and self-insured employers are entitled to reimbursement for reasonable and necessary claims expense incurred in determining liability, including expenses for attorneys' fees, court and litigation costs, witnesses and expert testimony, examinations, and autopsies. These types of costs are known as "allocated claims expenses," and the specific expenses must be itemized and documented. An insurance carrier may also claim "unallocated claims expenses" in an amount of up to 15% of the sum of the reimbursable medical, compensation, and burial payments.

Unallocated claims expenses represent the cost incurred by the company handling the claim in its regular course of operations. These expenses cannot be specifically itemized or documented.

For additional information, review the regulations governing the administration of the WHCA 42 U.S.C. 1701 issued December 2, 1942, and amended in 1943, 1946, 1953, 1958, 1959, and 1961.

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 this information is estimated to average 30 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. The authority for requesting this information is 42 U.S.C. 1701 et seq. The information will be used to determine entitlement to benefits. This collection of information is required to obtain or retain benefits. Furnishing the requested information is voluntary, but failure to provide the requested information may result in denial of the request for reimbursement. 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, OWCP, Room S3229, 200 Constitution Avenue, NW, Washington, D.C., 20210, and reference OMB Control Number 1240-0006. DO NOT SEND THE COMPLETED FORM TO THIS ADDRESS.

Request 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.