# Report of Earnings

(Longshore and Harbor Workers' Compensation Act, as Extended)

Print Reset

**U.S. Department of Labor**

Office of Workers' Compensation Programs

https://www.dol.gov/agencies/owcp/dlhwc

**Instructions to Employee:** You are required to complete and sign this form and return it to the employer/ insurance carrier/ special fund listed in item 4 within 30 days after receipt even if you have no earnings to report. (20 CFR 702.286) See page 2 for definition of "Earnings" and additional instructions. Loss of compensation benefits may result if this form is not completed and filed in accordance with instructions.

OMB No.: 1240-0014
Expires: 11/30/2026

1. Name and Address of Employee (Type or print)

2. OWCP No.

3. Carrier's No.

4. Name of Employer/Insurance Carrier/ Special Fund

5. Address of Employer/ Insurance Carrier/ Special Fund
line1 city
line2 st zip

6. Period for which earnings from employment or self-employment must be reported
From To

7. Have you had any earnings from employment or self-employment during the period shown in item 6? (See page 2 for definition of "earnings")
☐ Yes ☐ No

8. Complete the following if you had earnings from employment during the period shown in item 6.

| Name and Address of Employer | Periods of Employment From | To | Amount Earned |
|---|---|---|---|
| name city st zip | | | |
| name city st zip | | | |
| name city st zip | | | |

9. Complete the following if you had earnings from self-employment during the period shown in item 6.

| Type of Business or Service | Dates Performed From | To | Gross Revenue Received | Profits or Net Earnings Received |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

10. I certify that the above information I have provided is true, complete and correct to the best of my knowledge and belief.

Signature _____ Telephone No. _____ Date _____

Print Name

**IMPORTANT NOTICE**

Section 31 (a)(1) of the Longshore Act, 33 U.S.C. 931 (a)(1), provides as follows: Any claimant or representative of a claimant who knowingly and willfully makes a false statement or representation for the purpose of obtaining a benefit or payment under this Act shall be guilty of a felony, and conviction thereof shall be punished by a fine not to exceed $10.000, by imprisonment not to exceed five years, or both.

## INSTRUCTIONS TO EMPLOYEE

You are required to report on this form all earnings from employment or self- employment earned during the period specified on page 1 of this form (20 CFR 702.286). An employee who fails to report his/her earnings when requested or knowingly and willfully omits or understates any part of such earnings may forfeit his/her right to compensation with respect to any period during which this report is required. Compensation forfeited, if already paid, shall be deducted from any future compensation which may be due in accordance with a schedule determined by the District Director of the Office of Workers' Compensation Programs, Division of Longshore and Harbor Workers' Compensation, having jurisdiction in the case. (33 U.S.C. 908(j).

Earnings are defined as all monies received from any employment and includes but is not limited to wages, salaries, tips, sales commissions, fees for services provided, piecework and all revenue received from self- employment even if the business or enterprise operated at a loss or if the profits were reinvested.

An employer, insurance carrier, or the Director of the Office of Workers' Compensation Programs, Division of Longshore and Harbor Workers' Compensation (for those cases being paid from the Special Fund) may require an employee to file this report semiannually. The information provided will be used to determine entitlement to benefits. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number.

## TO SUBMIT FORMS TO THE DEPARTMENT OF LABOR

Please be sure to include the OWCP Case Number and mail to the OWCP/DLHWC Central Mail Receipt site 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 (preferred method) the form directly to the case file using our Secure Electronic Access Portal (SEAPortal)
Access the SEAPortal directly at https://seaportal.dol.gov/portal/

## FAILURE TO GIVE WRITTEN NOTICE MAY RESULT IN SOME LOSS OF BENEFITS.

## PRIVACY ACT STATEMENT

Privacy Act of 1974 as amended (5 U.S.C. 552a), section 901 of Title 33 to the US Code and 20 CFR 702.285 authorizes collection of this information. The purpose of this information is to determine eligibility for the amount of benefits payable under the Longshore and Harbor Workers' Compensation Act (LHWCA). Completion of this form is not mandatory; however, failure to provide the information may result in the loss of compensation benefits. Additional disclosures of this information may be to: (1) the employer which employed the claimant at the time of injury, or to the insurance carrier or other entity which secured the employer's compensation liability. (2) Physicians and other medical service providers for use in providing treatment or medical/vocational rehabilitation, making evaluations and for other purposes relating to the medical management of the claim. (3) the Department of Labor's Office of Administrative Law Judges (OALJ), or other person, board or organization, which is authorized or required to render decisions with respect to the claim or other matter arising in connection with the claim. (4) Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the LHWCA 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. (5) Failure to disclose all requested information may delay the processing of the claim, the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

## 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 10 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 optional, however furnishing the information is required in order to obtain and/ or retain benefits. (20 CFR 702.285). Send comments regarding the burden estimated 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.