U.S. DEPARTMENT OF LABOR
Office of Workers' Compensation Programs
Division of Longshore and Harbor Workers' Compensation

REPORT OF PAYMENTS

Print Reset

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

This report is required by law, (33 U.S.C.901 et seq.). Submit the completed form electronically as prescribed by OWCP (20 C.F.R. 703.2(a)) via LEAFS using the following hyperlink: https://seaportal.dol.gov/portal/?leaf&program_name=LS. All supporting documents must be submitted in Excel format only. Failure to report can result in termination of authorization to provide coverage.
Show number of cases and all payments made during the calendar year _____ under the following acts:

Compensation Act	Authorization Number	No. of Cases Compensated	Compensation Payments	Medical Payments
Longshore				
Defense Base Act				
— Department of Defense				
— Dep't of Homeland Security				
— Department of State				
— General Services Administration				
— US Agency for Int'l Development				
— Other (Please Specify)				
— Other (Please Specify)				
Nonappropriated Fund				
Outer Continental Shelf				
District of Columbia				
	Totals			

Enter "None" in spaces where no payment was made

Company Name and Address

Seq. No.

I certify that I am an officer or official of the insurance company or self-insurer named above and am duly authorized to file this report, and that I have carefully examined the facts contained herein and they are true to the best of my knowledge.

Any person who knowingly and willfully makes a false statement or conceals a material fact shall be fined not more than $10,000 or imprisoned not more than five years, or both (18 U.S.C. 1001).

Signature _____ Printed name _____

Title (Print or Type) _____ Date _____

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 30 minutes/hours 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 obligation to respond to this collection is "required to obtain or retain benefits" . 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, Office of Workers' Compensation Programs, 200 Constitution Avenue, N.W., Room S-3524, Washington, DC 20210. Note: Please do not return the completed form to this address.