Claim for Death Benefits

See Instructions On Reverse Print Reset

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

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

1. Name of deceased employee (First, Middle Initial, Last)

First (given name) M.I. Last (surname)

a. Social Security Number (Required by Law)

Deceased Date of Birth (mm/dd/yyyy)

OWCP Number

Carrier's Number

2. Last address of deceased (number, street, city, state, ZIP, country)

United States

3. Name and address of employer (number, street, city, state, ZIP)

3a. Injury is reported under the: Defense Base Act

8. Place of Death

9. Date of Death (mm/dd/yyyy)

10. Exact place where accident occurred (Street address, city, town, country) (For Longshore also include: name of vessel, pier, terminal, etc.) (For DBA also include: name of the DOD facility or associated worksite - i.e. base, FOB, camp, etc.)

United States

11. Date of Injury (mm/dd/yyyy)

4. Name and address of undertaker

5. Amount of undertaker's bill

6. Amount Paid

7. Name of person paying undertaker's bill

12. Nature of injury or occupational Illness and cause of death (Give parts of body affected if Injured)

13. Name and address of last attending physician (or hospital)

14. Widow or Widower

a. Full name and address

Name: City:

Line 1: State: Zip:

Line 2: Country: United States

Telephone Number

Email:

b. Social Security Number

c. Date of birth

d. Nationality

e. Date married to deceased (mm/dd/yyyy)

f. Place of marriage (City, State, Country)

United States

g. Signature of widow, widower, and/or guardian of children. If signed on behalf of claimant, submit a Notice of Representation or Power of Attorney

Date (mm/dd/yyyy)

15. Children of deceased (see page 2 for qualification)

a. Full name	b. Address	c. Social Security Number (Required by Law)	d. Date of birth (mm/dd/yyyy)	e. Nationality

16. All other persons partially or wholly dependent on deceased support (See page 2 for instructions)

a. Full name and address	b. income for one year preceding death Source	Amount	c. Relationship	d. Age	e. Dependent Wholly	Partially
					☐	☐
Signature Date (mm/dd/yyyy) Guardian? ☐						
f. Full name and address					☐	☐
Signature Date (mm/dd/yyyy) Guardian? ☐						

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 on conviction thereof shall be punished by a fine not to exceed $10,000, by imprisonment not to exceed five years, or by both.

Instructions:

1. Use this form to claim death benefits under the Longshore and Harbor Workers' Compensation Act, Defense Base Act, Outer Continental Shelf Lands Act, or Nonappropriated Fund Instrumentalities Act. The information provided will be used to determine entitlement to benefits.

2. Widow(er) email is optional.

3. Please submit electronically through the DLHWC's Secure Electronic Access Portal (SEAPortal) (preferred method) https://seaportal.dol.gov/portal/

Alternatively, submit the claim by mail to the Central Mail Receipt site at:
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
(Please be sure to include your case number.)

3. Individual claims must be filed by or in behalf of each person eligible for benefits [33 U.S.C. 913(a)]. (Included are grandchildren, brothers and sisters under 18 years, parents, step-parents, parents by adoption, parents-in-law, and any person who for more than one year prior to the employee's death stood in place of a parent to them.)

4. Under item 16(b), state all your income for the year preceding death by source (Social Security pension, bonds, etc.) and amount. List separately support deceased furnished you, including the value of any shelter, food, clothing, or other supplies. Use space below or additional sheets if needed.

5. A person other than the claimant may complete claim for the beneficiary.

6. Persons are not required to respond to this collection of information unless it displays a currently valid OMB number.

Conditions of Eligibility

Coverage for Death Benefit

A death benefit is payable under the Longshore Act, or related law, if a covered employee dies as a result of work-related injury or occupational disease.

Who is eligible for a Death Benefit?

1. The deceased worker's widow or widower living with or dependent for support at the time of death; or widow or widower living apart for good cause or because of desertion by worker.

2. Unmarried child(ren) under age 18, or if over 18: (a) was (were) wholly dependent on deceased worker and unable to support self(ves) because of mental or physical disability, or (b) student(s) up to age 23 (must meet certain requirements). Includes a posthumous child, legally adopted child, child to whom deceased acted as parent for one year before injury, stepchild, or acknowledged illegitimate child.

3. If the combined amount due a surviving widow or widower and child or children is not greater than two-thirds (66 and 2/3 percent) of the worker's average weekly wages subject to a maximum benefit of 200 percent of the national average weekly wage, a benefit is payable for any one of the following: Grandchildren, brothers or sisters (if dependent at time of injury), parents, grandparents, or others satisfying legal requirements of dependency. (Consult the Office of Workers' Compensation Programs for more information.)

What terminates widow's or widower's benefits?

1. Death

2. Remarriage, in which case the widow or widower receives a lump sum payment of two year's compensation.

What evidence is needed to support a claim?

1. Widow or widower. Proof of marriage to deceased worker. If either party was married before, proof that earlier marriage was legally ended. A certified copy of the final divorce decree, or proof of death of a previous marriage partner may be required before benefits are paid. Certified copy of the death certificate of the deceased worker.

2. Children - Certified copy of birth certificate or Order of Adoption. If a legal guardian has been appointed, a certified copy of the Letters of Guardianship.

Time requirement of filing claim

Within one year of employee's death. The time may not begin to run, however, until the person claiming the benefit would reasonably have related the employee's death to his or her employment. In case of death due to an occupational disease, a claim may be filed within two years after the claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship between the employment, the disease and the death.

Use the space below or a separate sheet of paper to continue answers. Please number each answer to correspond to the number of the item being continued.

Privacy Act Notice

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a) you are hereby notified that (1) the Longshore and Harbor Workers' Compensation Act, as amended and extended (33 U.S.C. 901 et seq.) (LHWCA) 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 LHWCA. (3) Information may be given to 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. (4) Information may be given to 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. (5) Information may be given to 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. (6) Information may be given to 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 or have been paid properly, and, where appropriate, to persue salary/administrative offset and debt collection actions required or permitted by law. 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, and for other purposes authorized by law. (8) 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.

Note: The notice applies to all forms requesting information that you might receive from the Office in connection with the processing and/or adjudication of the claim you filed under the LHWCA and related statutes.

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 15 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.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE