# Application for Continuation of Death Benefit for Student (under the Longshore and Harbor Workers' Compensation Act as extended)

Print Reset

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

INSTRUCTIONS: Submit this form for the dependent on whose behalf this application is filed to the Office of Workers' Compensation Programs (OWCP), Division of Longshore and Harbor Workers' Compensation (DLHWC) Central Mail Room, 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/

Have an official of the institution being attended by the dependent complete items in Part B. See reverse for requirement for qualifying as a student under the act. This form is authorized by law (33 U. S. C. 939(a)) and is required to obtain a benefit. Failure to submit this form may result in delay in receiving continuing death benefits for the student. See reverse for "Privacy Act" statement.

OMB No. 1240-0026
Expires: 11/30/2026

**FOR OFFICE USE**
OWCP No.
Carrier's No.

**PART A. (items 1 thru 12) To be completed by the Individual to whom benefits for a dependent child, grandchild, brother or sister are being paid**

1. Name of deceased upon whom dependency was based
First Name M.I. Last Name

2. Name of dependent
First Name M.I. Last Name

3. Is dependent now pursuing a full-time course of study or training?
☐ No - Skip to item 7 ☐ Yes - complete items 4, 5, and 6

Mark act under which benefit is being paid

A ☐ Longshore and Harbor Workers' Compensation Act
B ☐ Defense Base Act
C ☐ Nonappropriated Fund Instrumentalities Act
D ☐ Outer Continental Shelf Lands Act
E ☐ District of Columbia Compensation Act

4. Name and address of educational institution attended
name:
line 1: city: country:
line 2: state: zip:

5. Date attendance at this institution began (mm/dd/yyyy)

6. Does dependent expect to complete education or training at this institution?
☐ No ☐ Yes - enter month, year month year ☐ Don't know

7. Does dependent intend to go to school next year?
☐ No ☐ Yes - complete item 8 ☐ Don't know

8. Name and address of school where accepted or intends to enroll
name:
line 1: city: country:
line 2: state: zip:

9. **I hereby certify that the information given by me on and in connection with this questionnaire is true and correct to the best of my knowledge and belief.**

10. Signature of parent or guardian (Person to whom benefits are being paid)

10a. Print name of parent or guardian Phone #

11. Address No., street, city, state, ZIP Code)
line 1: city:
line 2: st: zip:
country:

12. Date (mm/dd/yyyy)

**PART B. To be completed by an official of the institution named in item 4**

**13. I have read the foregoing and those facts which I am normally able to verify are correct. Please note below any exceptions**

14. If your institution is neither a high school, college, or university, please state the agency by which it is accredited or licensed.

15. Signature and title (type and sign)

15a. Name, address and phone number of educational institution
name:
address:
email: Phone:

16. Date signed (mm/dd/yyyy)

# REQUIREMENTS FOR QUALIFYING AS A STUDENT FOR CONTINUING BENEFITS AFTER AGE 18

To qualify for a continuing death benefit after reaching the age of 18 years, under the Longshore and Harbor Workers' Compensation Act or one of the Act's extensions, a child, grandchild, brother, or sister must be either (1) incapable of self-support by reason of mental or physical disability, or (2) be a student, regularly pursuing a full-time course of study or training at an institution which is-

1. A school, college, or university operated or directly supported by the United States, or by any State or local government or political sub-division thereof,

2. A school, college, or university which has been accredited by a State recognized or nationally recognized accrediting agency or body,

3. A school, college, or university not so accredited but whose credits are accepted, on transfer, by not less than three institutions which are so accredited, for credit on the same basis as if transferred from an institution so accredited, or

4. An additional type of educational or training institution as defined by the Secretary of Labor.

Compensation may be paid so long as a dependent continues to pursue a full-time course of study at a recognized institution. In no event may compensation be paid beyond the end of the semester or enrollment period after the dependent reaches the age of 23 or has completed four years of education. A child shall not be deemed to have ceased to be a student during any period between school years if the period does not exceed five months and if he or she shows to the satisfaction of the Secretary of Labor that he has a bona fide intention of continuing to pursue a full-time course of education or training during the semester or other enrollment period immediately following the period or during periods of reasonable duration during which, in the judgment of the Secretary, the dependent is prevented by factors beyond his or her control.

A child or dependent shall not be deemed to be a student under this Act during a period of service in the Armed Forces of the United States.

**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/

## PRIVACY ACT OF 1974 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 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 pursue salary/administrative offset and debt collection actions required or permitted by law.

**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 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. Use of this form is optional, however furnishing the information is required in order to obtain and/or retain benefits (33 U.S.C. 939(a)). 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, N.W., Room S-3524, Washington, D.C. 20210, and reference the OMB Control Number.

**DO NOT SEND COMPLETED FORMS TO THIS OFFICE.**