# Notice of Payments

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

Print Reset

## U.S. Department of Labor

Office of Workers' Compensation Programs

Information collected on this form will be used to determine whether compensation payments were timely and properly made under the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 901 et seq., and its extensions, the Defense Base Act, 42 U.S.C. 1651 et seq., the Outer Continental Shelf Lands Act, 43 U.S.C. 1333(b), the Nonappropriated Funds Instrumentalities Act, 5 U.S.C. 8171, et seq., and the District of Columbia Workers' Compensation Act of 1928, D.C. Code 1928, 36-501 et seq. 33 U.S.C. 914. Use of this form is mandatory. 33 U. S.C. 914(c), (g). In Item 12, check the box for the type of payment you are reporting. Complete the remainder of the form as appropriate.

OMB No. 1240-0041
Expires: 08-31-2021

| 1. Date of Accident/Illness: | 2. Carrier's No. | 3. OWCP No. |
|---|---|---|

4. Name of Injured Worker and Claimant *if other than injured worker*:

5. Claimant's Address:

6. Compensation Disability type:

7. Date employee first lost time (Month, day, year)

8. Average Weekly Wage $ _____ Compensation Rate $ _____

*Subject to MIN/MAX rates*

9. Payment Begin Date (Month, day, year)

*If different than date of first lost time, state reason:*

10. Employer continuing to pay the injured person's salary?

☐ Yes ☐ No

If so, are salary continuation payments made in lieu of compensation payments.

☐ Yes ☐ No

11. Date first check issued (Month, day, year)

12. Type of Notice

☐ Initial (complete 6-11)

☐ Interim

☐ Final

13. State reason for interim or final payment notice:

14. Date last payment made:

15. **ENTER ALL PAYMENTS MADE ON ACCOUNT OF DISABILITY**

| TYPE OF DISABILITY a | FROM (Mo., day, yr.) b | THROUGH (Mo., day, yr.) c | AMOUNT PAID PER WEEK d | NUMBER OF WEEKS PAID e | TOTAL f |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| **PPD (**non-schedule**)** | | | | | |
| **Permanent partial** (schedule loss) **Percent** _____ **Part of body** _____ | | | | | |
| **Disfigurement** | | | | | |

Attach continuation sheet to show additional periods, rates and amounts: **TOTAL PAID:**

16. **ENTER OTHER PAYMENTS**

| | | | |
|---|---|---|---|
| a. Section 8(i) Settlement: 1. Compensation 2. Medical | | e. Beneficiary payments: Select type: / Select type: | |
| b. Compensation for late payment per Sec. 14(e) or (f) | | f. Funeral Expenses | |
| c. Interest | | g. Sec. 44(c)(1) payment to the Special Fund | |
| d. Attorney Fee | | h. Commutation | |

17. Employer Name:

18. Name of insurance carrier or self-insured employer and administrator:

17a. Employer Address:

18a. Address and phone number of person whose name is shown in Box 18:

**AS VERIFIED BY THE SIGNATURE BELOW, THIS FORM WAS MAILED TO THE CLAIMANT AND CLAIMANT'S REPRESENTATIVE**

| 19. Signature of person authorized to sign for employer or carrier | 20. Print name of authorized person: | 21. Date of notice: |
|---|---|---|

| | |
|---|---|
| **EMPLOYEE-PLEASE READ CAREFULLY** | **Any claim for compensation, to be valid, must be filed IN WRITING with the District Director, OWCP, WITHIN ONE YEAR after the date of injury or date of last payment of compensation. If you have any impairment of the body, serious disfigurement, or other disability from the injury which may handicap you in securing or maintaining employment you should submit a claim to the U. S. Department of Labor. Please be sure to include the OWCP Case Number.** |



Form LS-208
Rev. 01/2018

## INSTRUCTIONS TO THE EMPLOYER/INSURANCE CARRIER

**A COPY OF THE FORM MUST BE MAILED TO THE CLAIMANT AND THE CLAIMANT'S REPRESENTATIVE.**

This form must be filed with the Department of Labor to report disability or death compensation payments, as well as other statutory payments, in three situations.

(1) You must file this form the same day you make a first payment of compensation. 20 C.F.R. 702.234. Failure to do so may result in assessment of a penalty under 33 U.S.C. 930(b) and (e).

(2) You must file this form anytime you make an interim change in benefit payments. 20 C. F.R. 702.234. Failure to do so may result in assessment of a penalty under 33 U.S.C. 930(b) and (e) .

(3) You must file this form within 16 days of final payment of compensation. 33 U.S.C. 914(g), 20 C.F.R. 702.235. Failure to do so will result in assessment of a penalty in an amount established under 20 C.F.R. 702.236.

## INSTRUCTIONS TO INJURED WORKER

A claim may be filed within one year after the injury or death (33 U.S.C. 913(a)). If compensation has been paid without an award, a claim may be filed within one year after the last payment. Time for filing a claim does not begin to run until the employee or beneficiary knows, or should have known by the exercise of reasonable diligence, of the relationship between the employment and the injury. In cases involving occupational disease which does not immediately result in death or disability, a claim may be filed within two years after the employee or 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 or disability.

To file a claim for compensation, complete and sign an LS-203, Employee's Claim for Compensation. The form can be provided by your servicing district office nearest you https://www.dol.gov/owcp/dlhwc/lscontac.htm or you can obtain the form through our website: https://www.dol.gov/owcp/dlhwc/lsforms.htm

## TO SUBMIT FORMS TO 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 the form directly to the case file using our Secure Electronic Access Portal (SEAPortal).

Access the SEAPortal directly at seaportal.dol-esa.gov

## PRIVACY ACT STATEMENT

The following information is provided in accordance with the Privacy Act of 1974, 5 USC 552a. (1) This collection of information is authorized under the Longshore and Harbor Workers' Compensation Act (LHWCA) and its extensions. (2) The information will be used to determine beginning and ending dates of compensation payments, types and amounts of compensation payments, and reasons for terminating compensation. (3) Completion of this form is MANDATORY. (4) Disclosures of this information may be made to: the claimant and his or her representative(s); the employer that employed the injured worker at the time of injury; the insurance carrier or other entity that secured the employer's compensation liability and their representative (s); the Department of Labor's Office of Administrative Law Judges, or other person, board or organization, authorized or required to render decisions on claims or other matters arising in connection with a claim; Federal, state and local agencies 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; and other individuals, their representatives, and government agencies enforcing a legal obligation for alimony or child support. (5) An employer or insurance carrier's failure to timely provide the required information may result in penalties allowed by law. (6) This information is included in two Systems of Records, DOL/OWCP-3, 4, published at 81 *Federal Register* 25765, 25859-61 (April 29, 2016), or as updated and republished.

## Public Burden Statement

The time required to complete this information collection is estimated to range between 5 and 15 minutes which averages 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Division of Longshore and Harbor Workers' Compensation, Room C-4319, 200 Constitution Avenue, N.W., Washington, D.C. 20210. DO NOT SEND COMPLETED FORMS TO THIS OFFICE. You are not required to respond to this collection of information unless it displays a valid OMB control number.