Claimant's Statement

Print Reset

U.S. Department Of Labor

Employment Standards Administration
Office of Workers' Compensation Programs >>

Loss of compensation benefits may result if this report is not completed and filed in accordance with instructions (33 U.S.C. 944). | **OMB 1215-0160**

1. Place within brackets

Last Name | First Name | M.I.

line 1: | city:

line 2: | state: | zip:

country:

Name and Address of Beneficiary (Type or print)

2. OWCP No.

3. Carrier's No.

4. If you are receiving death benefits as a surviving spouse, please state whether you have remarried.

☐ **Yes** ☐ **No** **If "Yes", give name of spouse and date of marriage.**

5. If payments are being made on behalf of a beneficiary as a student, is the beneficiary still enrolled in school as a full-time student?

☐ Yes ☐ No

I hereby acknowledge receipt of compensation from the U.S. Department of Labor, Division of Longshore and Harbor Workers' Compensation, and certify that the above information is true and correct.

(Signature)	(Name of Signer)	(Date)
		02/09/2005

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.

Form LS-267
Rev. May 1998

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Public Burden Statement

We estimate that it will take an average of 2 minutes to complete this information collection including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information. If you have any comments regarding these estimates or any other aspect of this information collection, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Division of Longshore and Harbor Workers' Compensation, Room C4315, 200 Constitution Avenue, N.W., Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE**

This form is used to collect information relating to the payment of death benefits. The information provided will be used to determine entitlement to death benefits. Persons are not required to respond to the collection of information unless it displays a currently valid OMB Control Number.