Notice of Controversion of Right to Compensation

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U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
Longshore and Harbor Workers' Compensation

This report is required to obtain or retain benefits and is authorized by law and regulation (33 USC 914(d), (e); 20 CFR 702.251). Failure to report when controverting right to compensation can result in liability for 10 percent additional compensation.

OMB No. 1215-0023

Instructions: This form may be used by the employer/carrier to controvert the right to compensation. 33 USC 914(a) requires the employer to pay compensation promptly and without an award unless the right to such compensation is controverted by the filing of this form. Failure either to pay each installment of compensation, or controvert the right to such compensation, within fourteen days after it becomes due may result in liability for additional compensation equal to ten percent of each installment not paid when due (33 USC 914(d), (e). If the right to compensation is controverted, this form should be submitted in triplicate to the District Director, and the reasons for such controversion should be fully stated in item 12.

1. OWCP File No.

2. Employer File No.

3. Carrier File No.

4. Claimant's Name and Address *
First Name | M.I. | Last Name
name:
line 1: city: country:
line 2: state: zip:

5. Claim File or Injury Reported Under (check one) *
LHWCA | OCS | DCWCA | NFIA | DBA

6. Employee's Name and Address if different from Claimant's
city:
st: zip:
cnty:

7. Employer's Name, Address and Phone Number *
city:
st: zip:
cnty:

8. Carrier's Name, Address and Phone Number *
city:
zip:
phone: country:

9. Nature of Injury or Occupational Disease

10. Date of Injury (Month, Day, Year) *

11. Date of Employer's First Knowledge of Injury (Month, Day, Year) *

12. Right to compensation is controverted for the following reason(s) *

13. Authorized Signature *
Signature

14. Print Name and Phone Number *
phone:

15. Title *

16. Date of this Notice (Month, Day, Year) *
08/13/2009

17. (OWCP USE) A copy of this form was mailed to the claimant and/or representative

on _____ Initials _____

Public Burden Statement

The following statement is made in accordance with the Privacy Act of 1974 (5 USC 522a) and the Paperwork Reduction Act of 1995, as amended. The authority for requesting the following information is 20 CFR 702.251. Use of this form is optional, however furnishing the information is required in order to obtain and/or retain benefits. According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 1215-0023. The time required to complete this information collection is estimated to average 15 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 Worker's Compensation, Room C4315, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND COMPLETED FORMS TO THIS OFFICE.