Notice of Final Payment or Suspension of Compensation Payments

Print Reset

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

INSTRUCTIONS: This notice must be filed with the District Director within 16 days after compensation has been stopped or suspended. Use of this form is mandatory. Failure to timely file this form shall result in assessment of a penalty of $110.00. (33 U.S.C. 914(g)). This form is to be used to report disability or death compensation payments, as well as other statutory payments. The information will be used to verify the sufficiency of compensation paid under the Act.

OMB No.: 1240-0041

1. OWCP No.

2. Carrier's No.

3. Name and address of Employee or other beneficiary (Type or print)
Place within brackets

United States

a. Address of the OWCP District Office where this form is filed

CARRIER - Original (Copy 1) should be sent to the District Director. Copies 2, 3, 4 and 5 should be sent to the parties listed at the bottom of the form. Check the boxes at the bottom of the page to indicate parties copied.

4. Name of employer

5. Address of employer

6. Date of Iniury

7. Date employee first lost pay because of injury

7a. Date of first payment of compensation

8. Date physician found employee able to return to work

9. Date employee returned to work

10. Was compensation paid at the maximum rate? ☐ Yes ☐ No

Average weekly wage $ _____ multiplied by 2/3 = Compensation rate $ _____

11. State reason or reasons for termination or suspension of payments

12. Date last payment made

13. Date of this notice

14. **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
Temporary total					
Temporary total					
Temporary partial					
Permanent partial (Non-schedule)					
Permanent total					
Permanent partial (Schedule loss, facial or other disfigurement)	**Percent**	**Part of body**			
Attach continuation sheet to show additional periods, rates and amounts paid and enter total here. →					
			TOTAL PAID →		

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

a. Dependent name and date of birth	b. AMOUNT	c. OTHER PAYMENTS	d. AMOUNT
		Funeral Expenses	
		Sec. 44(c)(1) payment to the Special Fund	
(Attach continuation sheet)		**TOTAL** (cols. b + d) →	

16. **ENTER OTHER PAYMENTS**

a. Attorney fees		d. Sec. 8(i) Settlement	
b. Compensation for late payment per Sec. 14(e) or (f).		e. Commutation	
c. Interest		**TOTAL** (cols. a, b, c, d, e) →	

17. Name of insurance carrier or self-insured employer and claim administrator

a. Address and phone number of person whose name is shown in Box 19.

18. Signature of person authorized to sign for employer or carrier

19. Name and Title of person whose siqnature appears in Box 18

EMPLOYEE-PLEASE READ CAREFULLY

Any claim for compensation, to be valid, must be filed IN WRITING with the District Director, OWCP, VVITHIN ONE YEAR after the date of injury or date of last payment of compensation. If you have serious disfigurement of the face, head, or neck or other normally exposed areas which may handicap you in securing or maintaining employment, or any impairment of the body or other disability from the injury for which you have not received compensation, you should inform the District Director. (Address in 3a above)

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 702.235. 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 is 1240-0041. 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 Workers' Compensation, Room C4315, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND COMPLETED FORMS TO THIS OFFICE

☐ 1 - District Director ☐ 2 - Employer ☐ 3 - Insurance Carrier ☐ 4 - Employee ☐ 5 - Employee's Representative