Payment Of Compensation Without Award

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

U.S. Department of Labor

Office of Workers' Compensation Programs

Print Reset

OMB No. 1240-0043

NOTE: This Notice is to be filed with the District Director not later than the same day that first payment is made. A copy should be sent to the payee(s) AND to their attorney (if represented).

FOR OFFICE USE

1. OWCP No.

2. CARRIER'S No.

3. Name of injured person (First, middle, last - please print or type)

4. Address of injured person (Number, street, city, state and ZIP code)

United States

5. Date of accident or first illness (Month, day, year)

6. Date disability began (Month, day, year)

7. Name of injured, or dependents of injured, to whom compensation will be paid

8.

Average weekly wage $ _____

multiplied by 2/3 compensation rate $ _____

(Mark if maximum rate is being paid) ☐ Yes ☐ No

9. Compensation will be paid from - Enter month, day, year.

_____

until notice is given that payment has been stopped or suspended

9a. For DBA cases only, is the employer continuing to pay the injured person's salary? ☐ Yes ☐ No

9b. If so, are these salary continuation payments being made in lieu of compensation payments? ☐ Yes ☐ No

I0. Date of first payment (Month, day, year.)

11. Has medical care and treatment been provided by a physician or hospital chosen by the injured person?

(Mark appropriate box) ☐ Yes ☐ No

12. Name and address of employer (Name, number, street, city, state, ZIP code and country)

United States

13. Name and address of insurance carrier and/or claim administrator(Name, number, street, city, state, ZIP code and country)

United States

14. Authorized signature

15. Type or print title and name of person whose signature appears in item 14

Phone number

16. Date signed(mm-dd-yyyy)

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 10 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 accordance with 20CFR 702.234. 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, Room C4315, 200 Constitution Avenue, NW, Room C-4315, Washington, D.C. 20210, and reference the OMB Control Number.

DO NOT SEND COMPLETED FORMS TO THIS OFFICE.