U.S. Department of Labor

Office of Workers' Compensation Programs
Divsion of Longshore and
Harbor Workers' Compensation
Washington, D.C. 20210

OCT 11 2011

File Number:

Notice No. 136

NOTICE TO INSURANCE CARRIERS AND SELF-INSURED EMPLOYERS UNDER THE LONGSHORE AND HARBOR WORKERS' COMPENSATION ACT, AND OTHER INTERESTED PERSONS

SUBJECT: Newly Revised Form LS-206

Mandatory Longshore Form LS-206, Payment of Compensation Without Award, has been revised August, 2011. The revised form is now available for download and printing from the DLHWC website. http://www.dol.gov/owcp/dlhwc/lsforms.htm

Effective November 01, 2011, the revised version of the form should be used. All prior versions of the form are obsolete.

The August 2011 version of Form LS-206 contains changes and requires the following mandatory information and action:

- The instruction section at the top of the form has been revised and advises the form "is to be filed with the District Director not later than the same day that first payment is made."
- Adds Box 9(a) to allow the filer to check a yes or no block: "For DBA cases only, is the employer continuing to pay the injured person's salary?"
- Adds Box 9(b) to allow the filer to check a yes or no block: "If so, are these salary continuation payments being made in lieu of compensation payments?"

Questions regarding this revised form LS-206 should be addressed in writing to, Miranda Chiu, Acting Director Division of Longshore and Harbor Workers' Compensation, 200 Constitution Ave. N.W., Room C-4315 Washington, DC 20210. Also, you may send your inquiries to OWCP-public@dol.gov.

MIRANDA CHIU
Acting Director, Division of
Longshore and Harbor
Workers' Compensation

Payment Of Compensation Without Award

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

U.S. Department of Labor

Office of Workers' Compensation Programs

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

10. 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.