

# Payment Of Compensation Without Award

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

# U.S. Department of Labor

Employment Standards Administration  
Office of Workers' Compensation Programs



OMB No. 1215-0022

**NOTE: This Notice is to be filed with the District Director when the first payment is made. A copy should be sent to the person to whom compensation was paid. This report is mandatory (33 U.S.C. 914(c)). Failure to report may result in delays in the delivery of benefits. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.**

### FOR OFFICE USE

1. OWCP No.

2. CARRIER'S No.

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

First Name \* M.I. Last Name \*

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

line 1: city:  
line 2: state: zip: country:

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

First Name \* M.I. Last Name \*

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

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 of employer \*

13. Address of employer (Number, street, city, state and ZIP code) \*

line 1: city:  
line 2: state: zip: country:

14. Name of insurance carrier \*

15. Authorized signature \*

16. Title and name of person whose signature appears in item 15 \*

17. Date signed \*

### Public Burden Statement

We estimate that it will take an average of 15 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Division of Longshore and Harbor Workers' Compensation, U.S. Department of Labor, Room C4315, 200 Constitution Avenue, N.W., Washington, D.C. 20210. DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.