Claimant's Statement

Print Reset

U.S. Department Of Labor

Office of Workers' Compensation Programs

Loss of compensation benefits may result if this report is not completed and filed in accordance with instructions (33 U.S.C. 944).

OMB 1240-0014
Expires: 10/31/2023

1. Place within brackets

Name and Address of Beneficiary (Type or print)

US

2. OWCP No.

3. Carrier's No.

Telephone Number

4. If you are receiving death benefits as a surviving spouse, please state whether you have remarried.

☐ Yes ☐ No If "Yes", give name of spouse and date of marriage.

5. If payments are being made on behalf of a beneficiary as a student, is the beneficiary still enrolled in school as a full-time student? ☐ Yes ☐ No

I hereby acknowledge receipt of compensation from the U.S. Department of Labor, Division of Longshore and Harbor Workers' Compensation, and certify that the above information is true and correct.

(Signature) **(Name of Signer)** **(Date)**

Important Notice: Section 31 (a)(1) of the Longshore Act, 33 U.S.C. 931 (a)(1), provides as follows: Any claimant or representative of a claimant who knowingly and willfully makes a false statement or representation for the purpose of obtaining a benefit or payment under this Act shall be guilty of a felony, and on conviction thereof shall be punished by a fine not to exceed $10,000 by imprisonment not to exceed five years, or by both.

TO SUBMIT FORMS TO DEPARTMENT OF LABOR
with the exception of DCCA cases

Please be sure to include the OWCP Case Number and mail to the OWCP/DLHWC Central Mail Receipt site at the following address:
U.S. Department of Labor
Office of Workers' Compensation Programs
Division of Federal Employees', Longshore and Harbor Workers' Compensation
400 West Bay Street, Suite 63A, Box 28
Jacksonville, FL 32202

Or upload the form directly to the case file using our Secure Electronic Access Portal (SEAPortal).

Access the SEAPortal directly at https://seaportal.dol.gov/portal/?program_name=LS

Public Burden Statement

We estimate that it will take an average of 2 minutes to complete this information collection including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information. If you have any comments regarding these estimates or any other aspect of this information collection, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Division of Longshore and Harbor Workers' Compensation, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE**

This form is used to collect information relating to the payment of death benefits. The information provided will be used to determine entitlement to death benefits. Persons are not required to respond to the collection of information unless it displays a currently valid OMB Control Number.