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| (Longshore and Harbor Workers' Co. | | Office of Workers' Compensation P | 1 839.4 | | |
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| | with the District Director not later | FORO | FFICE USE | | |
| than the same day that f | irst payment is made. A copy should ND to their attorney (if represented). | 1. OWCP No. | 2. CARRIER'S No. | | |
| 3. Name of injured person (First, m | iddle, last - please print or type) | | | | |
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| 4. Address of injured person (Num | ber, street, city, state and ZIP code) | | | | |
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Payment Of Compensation Without Award

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



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

OMB No. 1240-0043

| NOTE: This Notice is to be filed with the District Director not later | · · · · · · · · · · · · · · · · · · · | FOR OFFICE USE | | | |
|---|---|---|---|---|--|
| NOTE: This Notice is to be filed with the District Director not later than the same day that first payment is made. A copy sho be sent to the payee(s) AND to their attorney (if represented | | 1. OWCP No. | 2. CARR | | |
| 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 | 6. Date disability began (Month, day, year) | | | | |
| 7. Name of injured, or dependents of injured, to whom compensation will be | e paid | | | | |
| 8. m | ultiplied | 1 by 2/3 compensation rate \$ | | | |
| Average weekly wage \$ | | naximum rate is being paid) | ΓY | es No | |
| Compensation will be paid from - Enter month, day, year. | | or DBA cases only, is the emp ured person's salary? | loyer con | | |
| ntil notice is given that payment has been stopped or suspended 9b. If so, are these salary continuation payments | | | | ents being made in | |
| 0. Date of first payment (Month, day, year.) | day, year.) lieu of comper | | Γ Ye | es No | |
| 11. Has medical care and treatment been provided by a physician or hospit (Mark appropriate box) | al chos | en by the injured person? | | | |
| 12. Name and address of employer (Name, number, street, city, state, ZIP code | and cou | untry) | | | |
| | | United | l States | | |
| 13. Name and address of insurance carrier and/or claim administrator(Name, | numbe | r, street, city, state, ZIP code a | nd countr | y) | |
| | | United | s States | | |
| 14. Authorized signature | | | | | |
| 15. Type or print title and name of person whose signature appears in item 14 Ph | | | Г 16. | Date signed(mm-dd-yyyy) | |
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DO NOT SEND COMPLETED FORMS TO THIS OFFICE.

Form LS-206 Rev. August 2011