SUBCHAPTER A—LONGSHOREMEN'S AND HARBOR WORKERS' COMPENSATION ACT AND RELATED STATUTES

PART 700 [RESERVED]

PART 701—GENERAL; ADMINISTERING AGENCY; DEFINITIONS AND USE OF TERMS

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SOURCE: 38 FR 26860, Sept. 26, 1973, unless otherwise noted.

RULES IN THIS SUBCHAPTER

§ 701.101 Scope of this subchapter and subchapter B.

(a) This subchapter contains the regulations governing the administration of the Longshore and Harbor Workers' Compensation Act, as amended (LHWCA), 33 U.S.C. 901 *et seq.*, except activities, pursuant to 33 U.S.C. 941, assigned to the Assistant Secretary of Labor for Occupational Safety and Health. It also contains the regulations governing the administration of the direct extensions of the LHWCA: the Defense Base Act (DBA), 42 U.S.C. 1651 *et seq.;* the Outer Continental Shelf Lands Act (OCSLA), 43 U.S.C. 1331; and the Nonappropriated Fund Instrumentalities Act (NFIA), 5 U.S.C. 8171 *et seq.*

(b) The regulations in this subchapter also apply to claims filed under the District of Columbia Workmen's Compensation Act (DCCA), 36 D.C. Code 501 *et seq.* That law applies to all claims for injuries or deaths based on employment events that occurred prior to July 26, 1982, the effective date of the District of Columbia Workers' Compensation Act, as amended (D.C. Code 32–1501 *et seq.*).

(c) The regulations governing the administration of the Black Lung Benefits Program are in subchapter B of this chapter.

[70 FR 43232, July 26, 2005]

§ 701.102 Organization of this subchapter.

Part 701 provides a general description of the regulations in this subchapter; sets forth information regarding the persons and agencies within the Department of Labor authorized by the Secretary of Labor to administer the Longshore and Harbor Workers' Compensation Act, its extensions and the regulations in this subchapter; and defines and clarifies use of specific terms in the several parts of this subchapter. Part 702 of this subchapter contains the general administrative regulations governing claims filed under the LHWCA. Part 703 of this subchapter

contains the regulations governing insurance carrier authorizations, insurance carrier security deposits, self-insurer authorizations, and certificates of compliance with the insurance regulations, as required by sections 32 and 37 of the LHWCA (33 U.S.C. 932, 937). Because the extensions of the LHWCA (*see* §701.101) incorporate by reference nearly all the provisions of the LHWCA, the regulations in parts 701, 702 and 703 also apply to the administration of the extensions (DBA, DCCA, OCSLA, and NFIA), unless otherwise noted. Part 704 of this subchapter contains the exceptions to the general applicability of parts 702 and 703 for the DBA, the DCCA, the OCSLA, and the NFIA.

[70 FR 43232, July 26, 2005]

OFFICE OF WORKERS' COMPENSATION PROGRAMS

§701.201 Office of Workers' Compensation Programs.

The Office of Workers' Compensation Programs is responsible for administering the LHWCA and its extensions.

[75 FR 63380, Oct. 15, 2010]

§§701.202–701.203 [Reserved]

DEFINITIONS AND USE OF TERMS

§701.301 What do certain terms in this subchapter mean?

(a) As used in this subchapter, except where the context clearly indicates otherwise:

(1) *Act* or *LHWCA* means the Longshore and Harbor Workers' Compensation Act, as amended (33 U.S.C. 901 *et seq.*), and includes the provisions of any statutory extension of such Act (*see* §701.101(a) and (b)) pursuant to which compensation on account of an injury is sought.

(2) *Secretary* means the Secretary of Labor, United States Department of Labor, or his authorized representative.

(3)–(4) [Reserved]

(5) *Office of Workers' Compensation Programs* or *OWCP* or *the Office* means the Office of Workers' Compensation Programs, referred to in §701.201. The term *Office of Workmen's Compensation Programs* shall have the same meaning as *Office of Workers' Compensation Programs* (*see* 20 CFR 1.6(b)).

(6) *Director* means the Director of OWCP, or his or her authorized representative.

(7) *District Director* means a person appointed as provided in sections 39 and 40 of the LHWCA or his or her designee, authorized to perform functions with respect to the processing and determination of claims for compensation under the LHWCA and its extensions as provided therein and under this subchapter. The term District Director is substituted for the term *Deputy Commissioner* used in the statute. This substitution is for administrative purposes only and in no way affects the power or authority of the position as established in the statute.

(8) *Administrative Law Judge* means a person appointed as provided in 5 U.S.C. 3105 and subpart B of 5 CFR part 930, who is qualified to preside at hearings under 5 U.S.C. 557 and is empowered by the Secretary to conduct formal hearings whenever necessary in respect of any claim for compensation arising under the LHWCA and its extensions.

(9) *Chief Administrative Law Judge* means the Chief Judge of the Office of Administrative Law Judges, United States Department of Labor, whose office is at the location set forth in 29 CFR 18.3(a).

(10) *Board or Benefits Review Board* means the Benefits Review Board established by section 21 of the LHWCA (33 U.S.C. 921) as amended and constituted and functioning pursuant to the provisions of chapter VII of this title and Secretary of Labor's Order No. 38–72 (38 FR 90), whose office is at the location set forth in 20 CFR 802.204.

(11) *Department* means the United States Department of Labor.

(12) *Employer* includes any employer who may be obligated as an employer under the provisions of the LHWCA as amended or any of its extensions to pay and secure compensation as provided therein.

(13) *Carrier* means an insurance carrier or self-insurer meeting the requirements of section 32 of the LHWCA as amended and of this subchapter with respect to authorization to provide insurance fulfilling the obligation of an

employer to secure the payment of compensation due his employees under the LHWCA as amended or a statutory extension thereof.

(14) The terms *wages*, *national average weekly wage*, *injury*, *disability*, *death*, and *compensation* shall have the meanings set forth in section 2 of the LHWCA.

(15) *Claimant* includes any person claiming compensation or benefits under the provisions of the LHWCA as amended or a statutory extension thereof on account of the injury or death of an employee.

(b) The definitions contained in paragraph (a) of this section shall not be considered to derogate from any definitions or delimitations of terms in the LHWCA as amended or any of its statutory extensions in any case where such statutory definitions or delimitations would be applicable.

(c) As used in this subchapter, the singular includes plural and the masculine includes the feminine.

[38 FR 26860, Sept. 26, 1973, as amended at 42 FR 3848, Jan. 21, 1977; 50 FR 391, Jan. 3, 1985; 51 FR 4281, Feb. 3, 1986; 55 FR 28606, July 12, 1990; 70 FR 43233, July 26, 2005; 76 FR 82127, Dec. 30, 2011; 77 FR 37286, June 21, 2012]

§ 701.302 Who is an employee?

(a) *Employee* means any person engaged in maritime employment, including:

(1) Any longshore worker or other person engaged in longshoring operations;

(2) Any harbor worker, including a ship repairer, shipbuilder and shipbreaker; and

(3) Any other individual to whom an injury may be the basis for a compensation claim under the LHWCA as amended, or any of its extensions;

(b) The term does not include:

(1) A master or member of a crew of any vessel; or

(2) Any person engaged by a master to load or unload or repair any small vessel under eighteen tons net.

(c) Nor does this term include the following individuals (whether or not the injury occurs over the navigable waters of the United States) where it is first determined that they are covered by a state workers' compensation act:

(1) Individuals employed exclusively to perform office clerical, secretarial, security, or data processing work (but not longshore cargo checkers and cargo clerks);

(2) Individuals employed by a club (meaning a social or fraternal organization whether profit or nonprofit), camp, recreational operation (meaning any recreational activity, including but not limited to scuba diving, commercial rafting, canoeing or boating activities operated for pleasure of owners, members of a club or organization, or renting, leasing or chartering equipment to another for the latter's pleasure), restaurant, museum or retail outlet;

(3) Individuals employed by a marina, provided they are not engaged in its construction, replacement or expansion, except for routine maintenance such as cleaning, painting, trash removal, housekeeping and small repairs;

(4) Employees of suppliers, vendors and transporters temporarily doing business on the premises of a covered employer, provided they are not performing work normally performed by employees of the covered employer;

(5) Aquaculture workers, meaning those employed by commercial enterprises involved in the controlled cultivation and harvest of aquatic plants and animals, including the cleaning, processing or canning of fish and fish products, the cultivation and harvesting of shellfish, and the controlled growing and harvesting of other aquatic species; or

(6) Individuals employed to build any recreational vessel under sixty-five feet in length, or individuals employed to repair any recreational vessel, or to dismantle any part of a recreational vessel in connection with the repair of such vessel. For purposes of this paragraph, the special rules set forth at §§ 701.501 through 701.505 apply.

[76 FR 82127, Dec. 30, 2011]

COVERAGE UNDER STATE COMPENSATION PROGRAMS

§ 701.401 Coverage under state compensation programs.

(a) Exclusions from the definition of ''employee'' under § 701.301(a)(12), and the employees of small vessel facilities

otherwise covered which are exempted from coverage under §702.171, are dependent upon coverage under a state workers' compensation program. For these purposes, a worker or dependent must first claim compensation under the appropriate state program and receive a final decision on the merits of the claim, denying coverage, before any claim may be filed under this Act.

(b) The intent of the Act is that state law will apply to those categories of employees if it otherwise would. Accordingly, not withstanding any contrary state law, claims by any of the categories of workers excluded under §701.301 or 702.171 must be made to and processed by the state and a merit decision denying coverage on jurisdictional grounds must be made before coverage or benefits under the Act may be sought.

(c) The time for filing notice and claim under the Act (see subpart B of part 702) does not begin to run for purposes of claims by those workers or dependents described in §701.301(a)(12) and §702.171, until a final adverse decision denying coverage under a state compensation act is received.

[50 FR 392, Jan. 3, 1985]

SPECIAL RULES FOR THE RECREATIONAL VESSEL EXCLUSION FROM THE DEFINITION OF ''EMPLOYEE''

§ 701.501 What is a recreational vessel?

(a) *Recreational vessel* means a vessel—

(1) Being manufactured or operated primarily for pleasure; or

(2) Leased, rented, or chartered to another for the latter's pleasure.

(b) In applying the definition in paragraph (a) of this section, the following rules apply:

(1) A vessel being *manufactured* or *built*, or being repaired under warranty by its manufacturer or builder, is a *recreational vessel* if the vessel appears intended, based on its design and construction, to be for ultimate recreational uses. The manufacturer or builder bears the burden of establishing that a vessel is recreational under this standard.

(2) A vessel being *repaired*, *dismantled for repair*, or *dismantled at the end of its life* is not a *recreational vessel* if the vessel had been operating, around the time of its repair or dismantling, in one or more of the following categories on more than an infrequent basis—

(A) ''Passenger vessel'' as defined by 46 U.S.C. 2101(22);

(B) ''Small passenger vessel'' as defined by 46 U.S.C. 2101(35);

(C) ''Uninspected passenger vessel'' as defined by 46 U.S.C. 2101(42);

(D) Vessel routinely engaged in ''commercial service'' as defined by 46 U.S.C. 2101(5); or

(E) Vessel that routinely carries ''passengers for hire'' as defined by 46 U.S.C. 2101(21a).

(3) Notwithstanding paragraph (b)(2) of this section, a vessel will be deemed recreational if it is a *public vessel*, *i.e.*, a vessel owned or bareboat-chartered and operated by the United States, or by a State or political subdivision thereof, at the time of repair, dismantling for repair, or dismantling, provided that such vessel shares elements of design and construction with traditional recreational vessels and is not normally engaged in a military, commercial or traditionally commercial undertaking.

(c) All subsequent amendments to the statutes referenced in paragraph (b)(2) of this section and the regulations implementing those provisions in Title 46 of the Code of Federal Regulations will apply when determining whether a vessel is recreational.

[76 FR 82128, Dec. 30, 2011]

§ 701.502 What types of work may exclude a recreational-vessel worker from the definition of "employee"?

(a) An individual who works on recreational vessels may be excluded from the definition of ''employee'' when:

(1) The individual's date of injury is before February 17, 2009, the injury is covered under a State workers' compensation law, and the individual is employed to:

(i) Build any recreational vessel under sixty-five feet in length; or

(ii) Repair any recreational vessel under sixty-five feet in length; or

(iii) Dismantle any recreational vessel under sixty-five feet in length.

(2) The individual's date of injury is on or after February 17, 2009, the injury

is covered under a State workers' compensation law, and the individual is employed to:

(i) Build any recreational vessel under sixty-five feet in length; or

(ii) Repair any recreational vessel; or

(iii) Dismantle any recreational vessel to repair it.

(b) In applying paragraph (a) of this section, the following principles apply:

(1) ''Length'' means a straight line measurement of the overall length from the foremost part of the vessel to the aftmost part of the vessel, measured parallel to the center line. The measurement must be from end to end over the deck, excluding sheer. Bow sprits, bumpkins, rudders, outboard motor brackets, handles, and other similar fittings, attachments, and extensions are not included in the measurement.

(2) ''Repair'' means any repair of a vessel including installations, painting and maintenance work. Repair does not include alterations or conversions that render the vessel a non-recreational vessel under § 701.501. For example, a worker who installs equipment on a private yacht to convert it to a passenger-carrying whale-watching vessel is not employed to ''repair'' a recreational vessel. Repair also does not include alterations or conversions that render a non-recreational vessel recreational under § 701.501.

(3) ''Dismantle'' means dismantling any part of a vessel to complete a repair but does not include dismantling any part of a vessel to complete alterations or conversions that render the vessel a non-recreational vessel under § 701.501, or render the vessel recreational under § 701.501, or, if the date of injury is on or after February 17, 2009, to scrap or dispose of the vessel at the end of the vessel's life.

[76 FR 82128, Dec. 30, 2011]

§ 701.503 Did the American Recovery and Reinvestment Act of 2009 amend the recreational vessel exclusion?

Yes. The amended exclusion was effective February 17, 2009, the effective date of the American Recovery and Reinvestment Act of 2009.

[76 FR 82128, Dec. 30, 2011]

§ 701.504 When does the recreational vessel exclusion in the American Recovery and Reinvestment Act of 2009 apply?

(a) *Date of injury.* Whether the amended version applies depends on the date of the injury for which compensation is claimed. The following rules apply to determining the date of injury:

(1) *Traumatic injury.* If the individual claims compensation for a traumatic injury, the date of injury is the date the employee suffered harm. For example, if the individual injures an arm or leg in the course of his or her employment, the date of injury is the date on which the individual was hurt.

(2) *Occupational disease or infection.* Occupational illnesses and infections generally involve delayed onset of symptoms following exposure to a harmful workplace substance or condition. If the individual claims compensation for an occupational illness or infection, the date of injury is the date the individual was exposed to the substance or condition.

(3) *Hearing loss.* If the individual claims compensation for hearing loss, the date of injury is the date the individual was exposed to harmful workplace noise or other stimulus that is capable of causing hearing loss.

(4) *Death-benefit claims.* If the individual claims compensation for an employee's death, the date of injury is the date of the workplace event or incident that caused, hastened, or contributed to the death.

(5) *Cumulative trauma.* If the individual claims compensation for cumulative trauma, in which multiple traumas contribute to an overall medical condition, such as a neck condition resulting from repetitive motion, the date of injury is any date on which a workplace trauma worsened the individual's condition. A workplace event will not be deemed a contributing trauma if a corresponding worsening of the condition is due solely to its natural progression, rather than the workplace event.

(b) If the date of injury is before February 17, 2009, the individual's entitlement is governed by section 2(3)(F) as it existed prior to the 2009 amendment.

(c) If the date of injury is on or after February 17, 2009, the individual's entitlement is governed by the 2009 amendment to section 2(3)(F).

[76 FR 82128, Dec. 30, 2011]

§ 701.505 May an employer stop paying benefits awarded before February 17, 2009 if the employee would now fall within the exclusion?

No. If an individual was awarded compensation for an injury occurring before February 17, 2009, the employer must still pay all benefits awarded, including disability compensation and medical benefits, even if the employee would be excluded from coverage under the amended exclusion.

[76 FR 82129, Dec. 30, 2011]

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SOURCE: 38 FR 26861, Sept. 26, 1973, unless otherwise noted.

Subpart A—General Provisions

ADMINISTRATION

§ 702.101 Exchange of documents and information.

(a) Except as otherwise required by the regulations in this subchapter, all documents and information sent to OWCP under this subchapter must be submitted—

(1) In hard copy by postal mail, commercial delivery service (such as Federal Express or United Parcel Service), or hand delivery;

(2) Electronically through an OWCP-authorized system; or

(3) As otherwise allowed by OWCP.

(b) Except as otherwise required by the regulations in this subchapter, all documents and information sent under this subchapter by OWCP to parties and their representatives or from any party or representative to another party or representative must be sent—

(1) In hard copy by postal mail, commercial delivery service (such as Federal Express or United Parcel Service), or hand delivery;

(2) Electronically by a reliable electronic method if the receiving party or representative agrees in writing to receive documents and information by that method; or

(3) Electronically through an OWCP-authorized system that provides service of documents on the parties and their representatives.

(c) Reliable electronic methods for delivering documents include, but are not limited to, email, facsimile and web portal.

(d) Any party or representative may revoke his or her agreement to receive documents and information electronically by giving written notice to OWCP, the party, or the representative with whom he or she had agreed to receive documents and information electronically, as appropriate.

(e) The provisions in paragraphs (a) through (d) of this section apply when parties are directed by the regulations in this subchapter to: Advise; apply; approve; authorize; demand; file; forward; furnish; give; give notice; inform; issue; make; notice, notify; provide; publish; receive; recommend; refer; release; report; request; respond; return; send; serve; service; submit; or transmit.

(f) Any reference in this subchapter to an application, copy, filing, form, letter, written notice, or written request includes both hard-copy and electronic documents.

(g) Any requirement in this subchapter that a document or information be submitted in writing, or that it be signed, executed, or certified does not preclude its submission or exchange electronically.

(h) Any reference in this subchapter to transmitting information to an entity's address may include that entity's electronic address or electronic portal.

(i) Any requirement in this subchapter that a document or information—

(1) Be sent to a specific district director means that the document or information should be sent to the physical or electronic address provided by OWCP for that district director; and

(2) Be filed by a district director in his or her office means that the document or information may be filed in a physical or electronic location specified by OWCP for that district director.

[80 FR 12928, Mar. 12, 2015]

§ 702.102 Establishment and modification of compensation districts, establishment of suboffices and jurisdictional areas.

(a) The Director has, pursuant to section 39(b) of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 939(b), established compensation districts as required for improved administration or as otherwise determined by the Director (see 51 FR 4282, Feb. 3, 1986). The boundaries of the compensation districts may be modified at any time, and the Director will notify all interested parties directly of the modifications.

(b) As administrative exigencies from time to time may require, the Director

may, by administrative order, establish special areas outside the continental United States, Alaska, and Hawaii, or change or modify any areas so established, notwithstanding their inclusion within an established compensation district. Such areas will be designated ''jurisdictional areas.'' The Director will also designate which of his district directors will be in charge thereof.

(c) To further aid in the efficient administration of the OWCP, the Director may from time to time establish suboffices within compensation districts or jurisdictional areas, and will designate a person to be in charge thereof.

[80 FR 12928, Mar. 12, 2015]

§ 702.103 Effect of establishment of suboffices and jurisdictional areas.

Whenever the Director establishes a suboffice or jurisdictional area, those reports, records, or other documents with respect to processing of claims that are required to be filed with the district director of the compensation district in which the injury or death occurred, may instead be required to be filed with the suboffice, or office established for the jurisdictional area.

[80 FR 12928, Mar. 12, 2015

§ 702.104 Transfer of individual case file.

(a) At any time after a claim is filed, the district director having jurisdiction thereof may, with the prior or subsequent approval of the Director, transfer such case to the district director in another compensation district for the purpose of making an investigation, ordering medical examinations, or taking such other action as may be necessary or appropriate to further develop the claim. If, after filing a claim, the claimant moves to another compensation district, the district director may, upon request by the claimant or the employer and with the approval of the Director, transfer the case to such other compensation district.

(b) The district director making the transfer may by letter or memorandum to the district director to whom the case is transferred give advice, comments, suggestions, or directions if appropriate to the particular case. All interested parties will be advised of the transfer.

[42 FR 45301, Sept. 9, 1977, as amended at 80 FR 12928, Mar. 12, 2015]

§ 702.105 Use of the title District Director in place of Deputy Commissioner.

Wherever the statute refers to Deputy Commissioner, these regulations have substituted the term District Director. The substitution is purely an administrative one, and in no way effects the authority of or the powers granted and responsibilities imposed by the statute on that position.

[55 FR 28606, July 12, 1990]

RECORDS

§ 702.111 Employer's records.

Every employer shall maintain adequate records of injury sustained by employees while in his employ, and which shall also contain information of disease, other impairments or disabilities, or death relating to said injury. Such records shall be available for inspection by the OWCP or by any State authority. Records required by this section shall be retained by the employer for three years following the date of injury; this applies to records for lost-time and no-lost-time injuries.

(Approved by the Office of Management and Budget under control number 1215–0160)

(Pub. L. No. 96–511, 94 Stat. 2812 (44 U.S.C. 3501 *et seq.*))

[38 FR 26861, Sept. 26, 1973, as amended at 47 FR 145, Jan. 5, 1982; 50 FR 393, Jan. 3, 1985]

§ 702.112 Records of the OWCP.

All reports, records, or other documents filed with the OWCP with respect to claims are the records of the OWCP. The Director shall be the official custodian of those records maintained by the OWCP at its national office, and the district director shall be the official custodian of those records maintained at the headquarters office in each compensation district.

§ 702.113 Inspection of records of the OWCP.

Any party in interest may be permitted to examine the record of the

case in which he is interested. The official custodian of the record sought to be inspected shall permit or deny inspection in accordance with the Department of Labor's regulations pertaining thereto (see 29 CFR part 70). The original record in any such case shall not be removed from the office of the custodian for such inspection. The custodian may, in his discretion, deny inspection of any record or part thereof which is of a character specified in 5 U.S.C. 552(b) if in his opinion such inspection may result in damage, harm, or harassment to the beneficiary or to any other person. For special provisions concerning release of information regarding injured employees undergoing vocational rehabilitation, see § 702.508.

§ 702.114 Copying of records of OWCP.

Any party in interest may request copies of records he has been permitted to inspect. Such requests shall be addressed to the official custodian of the records sought to be copied. The official custodian shall provide the requested copies under the terms and conditions specified in the Department of Labor's regulations relating thereto (see 29 CFR part 70).

FORMS

§ 702.121 Forms.

The Director may from time to time prescribe, and require the use of, forms for the reporting of any information required to be reported by the regulations in this subchapter, or by the Act or any of its extensions.

REPRESENTATION

§ 702.131 Representation of parties in interest.

(a) Claimants, employers and insurance carriers may be represented in any proceeding under the Act by an attorney or other person previously authorized in writing by such claimant, employer or carrier to so act.

(b) The Secretary shall annually publish a list of individuals who are disqualified from representing claimants under the Act. Individuals on this list are not authorized to represent claimants under the Act subject to the provision of section 31(b)(2)(C) of the Act, 33 U.S.C. 931(b)(2)(C), and they shall not have their representation fee approved as provided in section 28(e), 33 U.S.C. 928(e).

(c) Individuals shall be included on the list mentioned in (b) if the Secretary determines, after proceedings under §§ 702.432(b) through 702.434, that such individual:

(1) Has been convicted (without regard to pending appeal) of any crime in connection with the representation of a claimant under this Act or any workers' compensation statute;

(2) Has engaged in fraud in connection with the presentation of a claim under this or any workers' compensation statute, including, but not limited to, knowingly making false representations, concealing or attempting to conceal material facts with respect to a claim, or soliciting or otherwise procuring false testimony;

(3) Has been prohibited from representing claimants before any other workers' compensation agency for reasons of professional misconduct which are similar in nature to those which would be grounds for disqualification under this section; or

(4) Has accepted fees for representing claimants under the Act which were not approved, or which were in excess of the amount approved pursuant to section 28 of the Act, 33 U.S.C. 928.

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 394, Jan. 3, 1985]

§ 702.132 Fees for services.

(a) Any person seeking a fee for services performed on behalf of a claimant with respect to claims filed under the Act shall make application therefor to the district director, administrative law judge, Board, or court, as the case may be, before whom the services were performed (See 33 U.S.C. 928(c)). The application shall be filed and serviced upon the other parties within the time limits specified by such district director, administrative law judge, Board, or court. The application shall be supported by a complete statement of the extent and character of the necessary work done, described with particularity as to the professional status (e.g., attorney, paralegal, law clerk, or other person assisting an attorney) of

each person performing such work, the normal billing rate for each such person, and the hours devoted by each such person to each category of work. Any fee approved shall be reasonably commensurate with the necessary work done and shall take into account the quality of the representation, the complexity of the legal issues involved, and the amount of benefits awarded, and when the fee is to be assessed against the claimant, shall also take into account the financial circumstances of the claimant. No contract pertaining to the amount of a fee shall be recognized.

(b) No fee shall be approved for a representative whose name appears on the Secretary's list of disqualified representatives under § 702.131(b).

(c) Where fees are included in a settlement agreement submitted under § 702.241, *et seq*. approval of that agreement shall be deemed approval of attorney fees for purposes of this subsection for work performed before the Administrative Law Judge or district director approving the settlement.

[50 FR 394, Jan. 3, 1985]

§ 702.133 Unapproved fees; solicitation of claimants; penalties.

Under the provisions of section 28(e) of the Act, 33 U.S.C. 928(e), any person who receives any fees, other consideration, or any gratuity on account of services rendered as a representative of a claimant, unless such consideration or gratuity is approved under § 702.132, or who makes it a business to solicit employment for an attorney, or for himself in respect of any claim under the Act, shall upon conviction thereof, for each offense be punished by a fine of not more than $1,000 or by imprisonment for not more than 1 year, or by both fine and imprisonment.

§ 702.134 Payment of claimant's attorney's fees in disputed claims.

(a) If the employer or carrier declines to pay any compensation on or before the 30th day after receiving written notice from the district director of a claim for compensation having been filed, on the ground that there is no liability for compensation within the provisions of this Act, and the person seeking benefits shall thereafter have utilized the services of an attorney at law in the successful prosecution of his claim, there shall be awarded, in addition to the award of compensation, in a compensation order, a reasonable attorney's fee against the employer or carrier in an amount approved by the person, administrative body or court before whom the service was performed, which shall be paid directly by the employer or carrier to the attorney for the claimant in a lump sum after the compensation order becomes final (Act, section 28(a)).

(b) If the employer or carrier pays or tenders payment of compensation without an award pursuant to § 702.231 and section 14 (a) and (b) of this Act, and thereafter a controversy develops over the amount of additional compensation, if any, to which the employee may be entitled, the district director, administrative law judge, or Board shall set the matter for an informal conference and following such conference the district director, administrative law judge, or Board shall recommend in writing a disposition of the controversy. If the employer or carrier refuses to accept such written recommendation, within 14 days after its receipt by them, they shall pay or tender to the employee in writing the additional compensation, if any, to which they believe the employee is entitled. If the employee refuses to accept such payment or tender of compensation, and thereafter utilizes the services of an attorney at law, and if the compensation thereafter awarded is greater than the amount paid or tendered by the employer or carrier, a reasonable attorney's fee based solely upon the difference between the amount awarded and the amount tendered or paid shall be awarded in addition to the amount of compensation. The foregoing sentence shall not apply if the controversy relates to degree or length of disability, and if the employer or carrier offers to submit the case for evaluation by physicians employed or selected by the district director, as authorized by section 7(e) of the Act and § 702.408, and offers to tender an amount of compensation based upon the degree or length of disability found by the independent medical report at such time as an evaluation of disability can be

made. If the claimant is successful in review proceedings before the Board or court in any such case an award may be made in favor of the claimant and against the employer or carrier for a reasonable attorney's fee for claimant's counsel in accord with the above provisions. In all other cases any claim for legal services shall not be assessed against the employer or carrier (see Act, section 28(b)).

§ 702.135 Payment of claimant's witness fees and mileage in disputed claims.

In cases where an attorney's fee is awarded against an employer or carrier there may be further assessed against such employer or carrier as costs, fees and mileage for necessary witnesses attending the hearing at the instance of claimant. Both the necessity for the witness and the reasonableness of the fees of expert witnesses must be approved by the hearing officer, the Board, or the court, as the case may be. The amounts awarded against an employer or carrier as attorney's fees, costs, fees and mileage for witnesses shall not in any respect affect or diminish the compensation payable under this Act (see Act, section 28 (d)).

INFORMATION AND ASSISTANCE FOR CLAIMANTS

§ 702.136 Requests for information and assistance.

(a) *General assistance.* The Director shall, upon request, provide persons covered by the Act with information and assistance relating to the Act's coverage and compensation and the procedures for obtaining such compensation including assistance in processing a claim.

(b) *Legal assistance to claimants.* The Secretary may, upon request, provide a claimant with legal assistance in processing a claim under the Act. Such assistance may be made available to a claimant in the discretion of the Solicitor of Labor or his designee at any time prior to or during which the claim is being processed and shall be furnished without charge to the claimant. Legal representation of the claimant in adjudicatory proceedings may be furnished in cases in which the Secretary's interest in the case is not adverse to that of the claimant.

(c) *Other assistance.* The district directors and their staff, as designees of the Director, shall promptly and fully comply with the request of a claimant receiving compensation for information about, and assistance in obtaining, medical, manpower, and vocational rehabilitation services (see also subparts D and E of this part).

COMMUTATION OF PAYMENTS AND SPECIAL FUND

§ 702.142 Commutation of payments; aliens not residents or about to become nonresidents.

(a) Pursuant to section 9(g) of the Act, 33 U.S.C. 909(g), compensation paid to aliens not residents, or about to become nonresidents, of the United States or Canada shall be in the same amount as provided for residents except that dependents in any foreign country shall be limited to surviving spouse and child or children, or if there be no surviving spouse or child or children, to surviving father or mother whom the employee has supported, either wholly or in part, for the period of 1 year prior to the date of injury, and except that the Director, OWCP, may, at his option, or upon the application of the insurance carrier he shall, commute all future installments of compensation to be paid to such aliens by paying or causing to be paid to them one-half of the commuted amount of such future installments of compensation as determined by the Director.

(b) Applications for commutation under this section shall be made in writing to the district director having jurisdiction, and forwarded by the district director to the Director, for final action.

(c) Applications for commutations shall be made effective, if approved by the Director, on the date received by the district director, or on a later date if shown to be appropriate on the application.

(d) Commutations shall not be made with respect to a person journeying abroad for a visit who has previously declared an intention to return and has stated a time for returning, nor shall any commutation be made except upon

the basis of a compensation order fixing the right of the beneficiary to compensation.

[50 FR 394, Jan. 3, 1985]

§ 702.143 Establishment of special fund.

Congress, by section 44 of the Act, 33 U.S.C. 944, established in the U.S. Treasury a special fund, to be administered by the Secretary. The Treasurer of the United States is the custodian of such fund, and all monies and securities in such fund shall be held in trust by the Treasurer and shall not be money or property of the United States. The Treasurer shall make disbursements from such funds only upon the order of the Director, OWCP, as delegatee of the Secretary. The Act requires that the Treasurer give bond, in an amount to be fixed and with securities to be approved by the Secretary of the Treasury and the Comptroller General of the United States, conditioned upon the faithful performance of his duty as custodian of such fund.

§ 702.144 Purpose of the special fund.

This special fund was established to give effect to a congressional policy determination that, under certain circumstances, the employer of a particular employee should not be required to bear the entire burden of paying for the compensation benefits due that employee under the Act. Instead, a substantial portion of such burden should be borne by the industry generally. Section 702.145 describes this special circumstance under which the particular employer is relieved of some of his burden. Section 702.146 describes the manner and circumstances of the input into the fund.

§ 702.145 Use of the special fund.

(a) *Under section 10 of the Act.* This section provides for initial and subsequent annual adjustments in compensation and continuing payments to beneficiaries in cases of permanent total disability or death which commenced or occurred prior to enactment of the 1972 Amendments to this Act (Pub. L. 92–576, approved Oct. 27, 1972). At the discretion of the Director, such payments may be paid directly by him to eligible beneficiaries as the obligation accrues, one-half from the special fund and one-half from appropriations, or he may require insurance carriers or self-insured employers already making payments to such beneficiaries to pay such additional compensation as the amended Act requires. In the latter case such carriers and self-insurers shall be reimbursed by the Director for such additional amounts paid, in the proportion of one-half the amount from the special fund and one-half the amount from appropriations. To obtain reimbursement, the carriers and self-insurers shall submit claims for payments made by them during previous periods at intervals of not less than 6 months. A form has been prescribed for such purpose and shall be used. No administrative claims service expense incurred by the carrier or self-insurer shall be included in the claim and no such expense shall be allowed. The amounts reimbursed to such carrier or self-insurer shall be limited to amounts actually due and previously paid to beneficiaries.

(b) Under section 8(f) of the Act (Second Injuries). In any case in which an employee having an existing permanent partial disability suffers injury, the employer shall provide compensation for such disability as is found to be attributable to that injury based upon the average weekly wages of the employee at the time of injury. If, following an injury falling within the provisions of section 8(c)(1)–(20), the employee with the pre-existing permanent partial disability becomes permanently and totally disabled after the second injury, but such total disability is found not to be due solely to his second injury, the employer (or carrier) shall be liable for compensation as provided by the provisions of section 8(c)(1)–(20) of the Act, 33 U.S.C. 908(c)(1)–(20) or for 104 weeks, whichever is greater. However, if the injury is a loss of hearing covered by section 8(c)(13), 33 U.S.C. 908(c)(13), the liability shall be the lesser of these periods. In all other cases of a second injury causing permanent total disability (or death), wherein it is found that such disability (or death) is not due solely to the second injury, and wherein the employee had a pre-existing permanent partial disability, the employer (or carrier) shall first pay

compensation under section 8(b) or (e) of the Act, 33 U.S.C. 908(b) or (e), if any is payable thereunder, and shall then pay 104 weeks compensation for such total disability or death, and none otherwise. If the second injury results in permanent partial disability, and if such disability is compensable under section 8(c)(1)–(20) of the Act, 33 U.S.C. 908(c)(1)–(20), but the disability so compensable did not result solely from such second injury, and the disability so compensable is materially and substantially greater than that which would have resulted from the second injury alone, then the employer (or carrier) shall only be liable for the amount of compensation provided for in section 8(c)(1)–(20) that is attributable to such second injury, or for 104 weeks, whichever is greater. However, if the injury is a loss of hearing covered by section 8(c)(13), 33 U.S.C. 908(c)(13), the liability shall be the lesser of these periods. In all other cases wherein the employee is permanently and partially disabled following a second injury, and wherein such disability is not attributable solely to that second injury, and wherein such disability is materially and substantially greater than that which would have resulted from the second injury alone, and wherein such disability following the second injury is not compensable under section 8(c)(1)–(20) of the Act, then the employer (or carrier) shall be liable for such compensation as may be appropriate under section 8(b) or (e) of the Act, 33 U.S.C. 908(b) or (e), if any, to be followed by a payment of compensation for 104 weeks, and none other. The term ''compensation'' herein means money benefits only, and does not include medical benefits. The procedure for determining the extent of the employer's (or carrier's) liability under this paragraph shall be as provided for in the adjudication of claims in subpart C of this part 702. Thereafter, upon cessation of payments which the employer is required to make under this paragraph, if any additional compensation is payable in the case, the district director shall forward such case to the Director for consideration of an award to the person or persons entitled thereto out of the special fund. Any such award from the special fund shall be by order of the Director or Acting Director.

(c) *Under sections 8(g) and 39(c)(2) of the Act.* These sections, 33 U.S.C. 908(g) and 939(c)(2), respectively, provide for vocational rehabilitation of disabled employees, and authorize, under appropriate circumstances, a maintenance allowance for the employee (not to exceed $25 a week) in additional to other compensation benefits otherwise payable for his injury-related disability. Awards under these sections are made from the special fund upon order of the Director or his designee. The district directors may be required to make investigations with respect to any case and forward to the Director their recommendations as to the propriety and need for such maintenance.

(d) *Under section 39(c)(2) of the Act.* In addition to the maintenance allowance for the employee discussed in paragraph (c) of this section, the Director is further authorized to use the fund in such amounts as may be necessary to procure the vocational training services.

(e) *Under section 7(e) of the Act.* This provision, 33 U.S.C. 907(e), authorizes payment by the Director from the special fund for special medical examinations, *i.e.*, those obtained from impartial specialists to resolve disputes, when such special examinations are deemed necessary under that statutory provision. The Director has the discretionary power, however, to charge the cost of such examination to the insurance carrier or self-insured employer.

(f) *Under section 18(b) of the Act.* This section, 33 U.S.C. 918(b), provides a source for payment of compensation benefits in cases where the employer is insolvent, or other circumstances preclude the payment of benefits due in any case. In such situations, the district director shall forward the case to the Director for consideration of an award from the special fund, together with evidence with respect to the employer's insolvency or other reasons for nonpayment of benefits due. Benefits, as herein used, means medical care or supplies within the meaning of section 7 of the Act, 33 U.S.C. 907, and subpart D of this part 702, as well as monetary benefits. Upon receipt of the case, the Director shall promptly determine

whether an award from the special fund is appropriate and advisable in the case, having due regard for all other current commitments from the special fund. If such an award is made, the employer shall be liable for the repayment into the fund of the amounts paid therefrom, as provided in 33 U.S.C. 918(b).

(The information collection requirements contained in paragraph (a) were approved by the Office of Management and Budget under control number 1215–0065. The information collection requirements contained in paragraph (b) were approved by the Office of Management and Budget under control number 1215–0073)

(Pub. L. No. 96–511)

[38 FR 26861, Sept. 26, 1973, as amended at 49 FR 18294, Apr. 30, 1984; 51 FR 4282, Feb. 3, 1986]

§ 702.146 Source of the special fund.

(a) All amounts collected as fines and penalties under the several provisions of the Act shall be paid into the special fund (33 U.S.C. 44(c)(3)).

(b) Whenever an employee dies under circumstances creating a liability on an employer to pay death benefits to the employee's beneficiaries, and whenever there are no such beneficiaries entitled to such payments, the employer shall pay $5,000 into the special fund (Act, section 44(c)(1)). In such cases, the compensation order entered in the case shall specifically find that there is such liability and that there are no beneficiaries entitled to death benefits, and shall order payment by the employer into the fund. Compensation orders shall be made and filed in accordance with the regulations in subpart C of this part 702, except that for this purpose the district director settling the case under § 702.315 shall formalize the memorandum of conference in a compensation order, and shall file such order as provided for in § 702.349.

(c) The Director annually shall assess an amount against insurance carriers and self-insured employers authorized under the Act and part 703 of this subchapter to replenish the fund. That total amount to be charged all carriers and self-insurers to be assessed shall be based upon an estimate of the probable expenses of the fund during the calendar year. The assessment against each carrier and self-insurer shall be based upon (1) the ratio of the amount each paid during the prior calendar year for compensation in relation to the amount all such carriers of self-insurers paid during that period for compensation, and (2) the ratio of the amount of payments made by the special fund for all cases being paid under section 8(f) of the Act, 33 U.S.C. 908(f), during the preceding calendar year which are attributable to the carrier or self-insurer in relation to the total of such payments during such year attributable to all carriers and self-insurers. The resulting sum of the percentages from paragraphs (c) (1) and (2) of this section will be divided by two, and the resulting percentage multiplied by the probable expenses of the fund. The Director may, in his or her discretion, condition continuance or renewal of authorization under part 703 upon prompt payment of the assessment. However, no action suspending or revoking such authorization shall be taken without affording such carrier or self-insurer a hearing before the Director or his/her designee.

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 395, Jan. 3, 1985; 51 FR 4282, Feb. 3, 1986]

§ 702.147 Enforcement of special fund provisions.

(a) As provided in section 44(d)(1) of the Act, 33 U.S.C. 944(d)(1), for the purpose of making rules, regulations, and determinations under the special fund provisions in section 44 and for providing enforcement thereof, the Director may investigate and gather appropriate data from each carrier and self-insured employer, and may enter and inspect such places and records (and make such transcriptions of records), question such employees, and investigate such facts, conditions, practices, or other matters as he may deem necessary or appropriate. The Director may require the employer to have audits performed of claims activity relating to this Act. The Director may also require detailed reports of payments made under the Act, and of estimated future liabilities under the Act, from any or all carriers of self-insurers. The Director may require that such reports be certified and verified in whatever manner is considered appropriate.

(b) Pursuant to section 44(d)(3) of the Act, 33 U.S.C. 944(d)(3), for the purpose of any hearing or investigation related to determinations or the enforcement of the provisions of section 44 with respect to the special fund, the provisions of 15 U.S.C. 49 and 50 as amended (the Federal Trade Commission Act provisions relating to attendance of witnesses and the production of books, papers, and documents) are made applicable to the jurisdiction, powers, and duties of the Director, OWCP, as the Secretary's delegatee.

(c) Civil penalties and unpaid assessments shall be collected by civil suits brought by and in the name of the Secretary.

(Approved by the Office of Management and Budget under control number 1215–0160)

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 395, Jan. 3, 1985]

§ 702.148 Insurance carriers' and self-insured employers' responsibilities.

(a) Each carrier and self-insured employer shall make, keep, and preserve such records, and make such reports and provide such additional information as the Director prescribes or orders, which he considers necessary or appropriate to effectively carry out his responsibilities.

(b) Consistent with their greater direct liability stemming from the amended assessment formula, employers and insurance carriers are given the authority to monitor their claims in the special fund as outlined in paragraph (c) of this section. For purposes of monitoring these claims, employers and insurance carriers remain parties in interest to the claim and are allowed access to all records relating to the claim. Similarly, employers and insurance carriers can initiate proceeding to modify an award of compensation after the special fund has assumed the liability to pay benefits. It is intended that employers and insurance carriers have neither a greater nor a lesser responsibility in this new role that they not have with regard to cases that remain their sole liability. (See § 702.373(d).)

(c) An employer or insurance carrier may conduct any reasonable investigation regarding cases placed into the special fund by the employer or insurance carrier. Such investigation may include, but shall not be limited to, a semi-annual request for earnings information pursuant to section 8(j) of the Act, 33 U.S.C. 908(j) (See § 702.285) periodic medical examinations, vocational rehabilitation evaluations, and requests for any additional information needed to effectively monitor such a case.

(Approved by the Office of Management and Budget under control number 1215–0118)

(Pub. L. No. 96–511, 94 Stat. 2812 (44 U.S.C. 3501 *et seq.*))

[38 FR 26861, Sept. 26, 1973, as amended at 47 FR 145, Jan. 5, 1982; 50 FR 395, Jan. 3, 1985]

LIENS ON COMPENSATION

§ 702.161 Liens against assets of insurance carriers and employers.

Where payments have been made from the special fund pursuant to section 18(b) of the Act, 33 U.S.C. 918(b) and § 704.145(f) the Secretary of Labor shall, for the benefit of the fund, be subrogated to all the rights of the person receiving such payments. The Secretary may institute proceedings under either section 18 or 21(d) of the Act, 33 U.S.C. 918 or 921(d), or both, to recover the amount expended by the fund or so much as in the judgement of the Secretary is possible, or the Secretary may settle or compromise any such claim.

[50 FR 395, Jan. 3, 1985]

§ 702.162 Liens on compensation authorized under special circumstances.

(a) Pursuant to section 17 of the Act, 33 U.S.C. 917, when a trust fund which complies with section 302(c) of the Labor-Management Relations Act of 1947, 29 U.S.C. 186(c) [LMRA], established pursuant to a collective bargaining agreement in effect between an employer and an employee entitled to compensation under this Act, has paid disability benefits to an employee which the employee is legally obligated to repay by reason of his entitlement to compensation under this Act, a lien shall be authorized on such compensation in favor of the trust fund for the amount of such payments.

(b)(1) An application for such a lien shall be filed on behalf of the trust

fund with the district director for the compensation district where the claim for compensation has been filed, 20 CFR 702.101. Such application shall include a certified statement by an authorized official of the trust fund that:

(i) The trust fund is entitled to a lien in its favor by reason of its payment of disability payments to a claimant-employee (including his name therein);

(ii) The trust fund was created pursuant to a collective bargaining agreement covering the claimant-employee;

(iii) The trust fund complies with section 302(c) of the Labor-Management Relations Act of 1947, 29 U.S.C. 186(c);

(iv) The trust agreement contains a subrogation provision entitling the fund to reimbursement for disability benefits paid to the claimant-employee who is entitled to compensation under the Longshoremen's Act;

(2) The statement shall also state the amount paid to the named claimant-employee and whether such disability benefit payments are continuing to be paid.

(3) If the claimant has signed a statement acknowledging receipt of disability benefits from the trust fund and/or a statement recognizing the trust fund's entitlement to a lien against compensation payments which may be received under the Longshoremen's and Harbor Worker's Compensation Act as a result of his present claim and for which the fund is providing disability payments, such statement(s) shall also be included with or attached to the application.

(c) Upon receipt of this application, the district director shall, within a reasonable time, notify the claimant, the employer and/or its compensation insurance carrier that the request for a lien has been filed and each shall be provided with a copy of the application. If the claimant disputes the right of the trust fund to the lien or the amount stated, if any, he shall, within 30 days after receipt of the application or such other longer period as the district director may set, notify the district director and he shall be given an opportunity to challenge the right of the trust fund to, or the amount of, the asserted lien; notice to either the employer or its compensation insurance carrier shall constitute notice to both of them.

(d) If the claim for compensation benefits is resolved without a formal hearing and if there is no dispute over the amount of the lien or the right of the trust fund to the lien, the district director may order and impose the lien and he shall notify all parties of the amount of the lien and manner in which it is to be paid.

(e) If the claimant's claim for compensation cannot be resolved informally, the district director shall transfer the case to the Office of the Chief Administrative Law Judge for a formal hearing, pursuant to section 19(d) of the Act, 33 U.S.C. 919(d), and 20 CFR 702.317. The district director shall also submit therewith the application for the lien and all documents relating thereto.

(f) If the administrative law judge issues a compensation order in favor of the claimant, such order shall establish a lien in favor of the trust fund if it is determined that the trust fund has satisfied all of the requirements of the Act and regulations.

(g) If the claim for compensation is not in dispute, but there is a dispute as to the right of the trust fund to a lien, or the amount of the lien, the district director shall transfer the matter together with all documents relating thereto to the Office of the Chief Administrative Law Judge for a formal hearing pursuant to section 19(d) of the Act, 33 U.S.C. 919(d), and 20 CFR 702.317.

(h) In the event that either the district director or the administrative law judge is not satisfied that the trust fund qualifies for a lien under section 17, the district director or administrative law judge may require further evidence including but not limited to the production of the collective bargaining agreement, trust agreement or portions thereof.

(i) Before any such lien is approved, if the trust fund has provided continued disability payments after the application for a lien has been filed, the trust fund shall submit a further certified statement showing the total amount paid to the claimant as disability payments. The claimant shall likewise be given an opportunity to

contest the amount alleged in this subsequent statement.

(j) In approving a lien on compensation, the district director or administrative law judge shall not order an initial payment to the trust fund in excess of the amount of the past due compensation. The remaining amount to which the trust fund is entitled shall thereafter be deducted from the affected employee's subsequent compensation payments and paid to the trust fund, but any such payment to the trust fund shall not exceed 10 percent of the claimant-employee's biweekly compensation payments.

(Approved by the Office of Management and Budget under control number 1215–0160)

[42 FR 45301, Sept. 9, 1977, as amended at 50 FR 395, Jan. 3, 1985; 51 FR 4282, Feb. 3, 1986]

CERTIFICATION OF EXEMPTION

§ 702.171 Certification of exemption, general.

An employer may apply to the Director or his/her designee to certify a particular facility as one engaged in the building, repairing or dismantling of exclusively small vessels, as defined. Once certified, injuries sustained at that facility would not be covered under the Act except for injuries which occur over the navigable waters of the United States including any adjoining pier, wharf, dock, facility over land for launching vessels or for hauling, lifting or drydocking vessels. A facility otherwise covered under the Act remains covered until certification of exemption is issued; a certification will be granted only upon submission of a complete application (described in § 702.174), and only for as long as a facility meets the requirements detailed in section 3(d) of the Act, 33 U.S.C. 903(d). This exemption from coverage is not intended to be used by employers whose facilities from time to time may temporarily meet the criteria for qualification but only for facilities which work on exclusively small vessels, as defined.

[50 FR 396, Jan. 3, 1985]

§ 702.172 Certification; definitions.

For purposes of §§ 702.171 through 702.175 dealing with certification of small vessel facilities, the following definitions are applicable.

(a)(1) ''Small vessel'' means only those vessels described in section 3(d)(3) of the Act, 33 U.S.C. 903(d)(3), that is:

(i) A commercial barge which is under 900 lightship displacement tons (long); or

(ii) A commercial tugboat, towboat, crewboat, supply boat, fishing vessel or other work vessel which is under 1,600 tons gross.

(2) For these purposes: (i) One gross ton equals 100 cubic feet, as measured by the current formula contained in the Act of May 6, 1894 as amended through 1974 (46 U.S.C. 77); (ii) one long ton equals 2,240 lbs; and (iii) ''Commercial'' as it applies to ''vessel'' means any vessel engaged in commerce but does not include military vessels or Coast Guard vessels.

(b) ''Federal Maritime Subsidy'' means the construction differential subsidy (CDS) or operating differential subsidy under the Merchant Marine Act of 1936 (46 U.S.C. 1101 *et seq.*).

(c) *facility* means an operation of an employer at a particular contiguous geographic location.

[51 FR 4283, Feb. 3, 1986]

§ 702.173 Exemptions; requirements, limitations.

(a) Injuries at a facility otherwise covered by the Act are exempted only upon certification that the facility is: (1) Engaged in the building, repairing or dismantling of exclusively small commercial vessels; and (2) does not receive a Federal maritime subsidy.

(b) The exemption does not apply to: (1) Injuries at any facility which occur over the navigable waters of the United States or upon any adjoining pier, wharf, dock, facility over land for launching vessels or for hauling, lifting or drydocking vessels; or (2) where the employee at such facility is not subject to a State workers' compensation law.

[50 FR 396, Jan. 3, 1985]

§ 702.174 Exemptions; necessary information.

(a) *Application.* Before any facility is exempt from coverage under the Act, the facility must apply for and receive

a certificate of exemption from the Director or his/her designee. The application must be made by the owner of the facility; where the owner is a partnership it must be made by a partner and where a corporation by an officer of the corporation or the manager in charge of the facility for which an exemption is sought. The information submitted must include the following:

(1) Name, location, physical description and a site plan or aerial photograph of the facility for which an exemption is sought.

(2) Description of the nature of the business.

(3) An affidavit (signed by a partner if the facility is owned by a partnership or an officer if owned by a corporation) vertifying and/or acknowledging that:

(i) the facility is, as of the date of the application, engaged in the business of building, repairing or dismantling exclusively small commercial vessels and that it does not then nor foreseeably will it engage in the building, repairing or dismantling of other than small vessels.

(ii) The facility does not receive any Federal maritime subsidy.

(iii) The signator has the duty to immediately inform the district director of any change in these or other conditions likely to result in a termination of an exemption.

(iv) the employer has secured appropriate compensation liability under a State workers' compensation law.

(v) Any false, relevant statements relating to the application or the failure to notify the district director of any changes in circumstances likely to result in termination of the exemption will be grounds for revocation of the exemption certificate and will subject the employer to all provisions of the Act, including all duties, responsibilities and penalties, retroactive to the date of application or date of change in circumstances, as appropriate.

(b) *Action by the Director*. The Director or his/her designee must review the application within thirty (30) days of its receipt.

(1) Where the application is complete and shows that all requirements under §702.173 are met, the Director must promptly notify the employer that certification has been approved and will be effective on the date specified. The employer is required to post notice of the exemption at a conspicuous location.

(2) Where the application is incomplete or does not substantiate that all requirements of section 3(d) of the Act, 33 U.S.C. 903(d), have been met, or evidence shows the facility is not eligible for exemption, the Director must promptly notify the employer by issuing a letter which details the reasons for the deficiency or the rejection. The employer/applicant may reapply for certification, correcting deficiencies and/or responding to the reasons for the Director's denial. The Director or his/her designee must issue a new decision within a reasonable time of reapplication following denial. Such action will be the final administrative review and is not appealable to the Administrative Law Judge or the Benefits Review Board.

(c) The Director or another designated individual at any time has the right to enter on and inspect any facility seeking exemption for purposes of verifying information provided on the application form.

(d) *Action by the employer*. Immediately upon receipt of the certificate of exemption from coverage under the Act the employer must post:

(1) A general notice in a conspicuous place that the Act does not cover injuries sustained at the facility in question, the basis of the exemption, the effective date of the exemption and grounds for termination of the exemption.

(2) A notice, where applicable, at the entrances to all areas to which the exemption does not apply.

(Approved by the Office of Management and Budget under control number 1215–0160)

[50 FR 396, Jan. 3, 1985, as amended at 51 FR 4283, Feb. 3, 1986; 80 FR 12928, Mar. 12, 2015]

§702.175 Effect of work on excluded vessels; reinstatement of certification.

(a) When a vessel other than a small commercial vessel, as defined in §702.172, enters a facility which has been certified as exempt from coverage, the exemption shall automatically terminate as of the date such a

vessel enters the facility. The exemption shall also terminate on the date a contract for a Federal maritime subsidy is entered into, and, in the situation where the facility undertakes to build a vessel other than a small vessel, when the construction first takes on the characteristics of a vessel, *i.e.*, when the keel is laid. All duties, obligations and requirements imposed by the Act, including the duty to secure compensation liability as required by sections 4 and 32 of the Act, 33 U.S.C. 904 and 932, and to keep records and forward reports, are effective immediately. The employer shall notify the Director or his/her designee immediately where this occurs.

(b) Where an exemption certification is terminated because of circumstances described in (a), the employer may apply for reinstatement of the exemption once the event resulting in termination of the exemption ends. The reapplication shall consist of a reaffirmation of the nature of the business, an explanation of the circumstances leading to the termination of exemption, and an affidavit by the appropriate person affirming that the circumstances prompting the termination no longer exists nor will they reoccur in the forseeable future and that the facility is engaged in building, repairing or dismantling exclusively small vessels. The Director or the Director's designee shall respond to the complete reapplication within ten working days of receipt.

[50 FR 397, Jan. 3, 1985, as amended at 51 FR 4283, Feb. 3, 1986]

Subpart B—Claims Procedures

EMPLOYER'S REPORTS

§ 702.201 Reports from employers of employee's injury or death.

(a) Within 10 days from the date of an employee's injury or death, or 10 days from the date an employer has knowledge of an employee's injury or death, including any disease or death proximately caused by the employment, the employer shall furnish a report thereof to the district director for the compensation district in which the injury or death occurred, and shall thereafter furnish such additional or supplemental reports as the district director may request.

(b) No report shall be filed unless the injury causes the employee to lose one or more shifts from work. However, the employer shall keep a record containing the information specified in § 702.202. Compliance with the current OSHA injury record keeping requirements at 29 CFR part 1904 will satisfy the record keeping requirements of this section for no lost time injuries.

(Approved by the Office of Management and Budget under control number 1215–0160)

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 397, Jan. 3, 1985; 51 FR 4283, Feb. 3, 1986]

§ 702.202 Employer's report; form and contents.

The employer's report of an employee's injury or death shall be in writing and on a form prescribed by the Director for this purpose, and shall contain:

(a) The name, address and business of the employer;

(b) The name, address, occupation and Social Security Number (SSN) of the employee;

(c) The cause, nature, and other relevant circumstances of the injury or death;

(d) The year, month, day, and hour when, and the particular locality where, the injury or death occurred;

(e) Such other information as the Director may require.

(Approved by the Office of Management and Budget under control numbers 1215–0031 and 1215–0063)

[58 FR 68032, Dec. 23, 1993]

§ 702.203 Employer's report; how given.

(a) The employer must file its report of injury with the district director.

(b) If the employer sends its report of injury by U.S. postal mail or commercial delivery service, the report will be considered filed on the date that the employer mails the document or gives it to the commercial delivery service. If the employer sends its report of injury by a permissible electronic method, the report will be considered filed on the date that the employer completes all steps necessary for the transmission.

[80 FR 12929, Mar. 12, 2015]

§ 702.204 Employer's report; penalty for failure to furnish and or falsifying.

Any employer, insurance carrier, or self-insured employer who knowingly and willfully fails or refuses to send any report required by § 702.201, or who knowingly or willfully makes a false statement or misrepresentation in any report, shall be subject to a civil penalty not to exceed $26,269 for each such failure, refusal, false statement, or misrepresentation for which penalties are assessed after January 15, 2022. The district director has the authority and responsibility for assessing a civil penalty under this section.

[81 FR 43449, July 1, 2016, as amended at 82 FR 5380, Jan. 18, 2017; 83 FR 11, Jan. 2, 2018; 84 FR 217, Jan. 23, 2019; 85 FR 2296, Jan. 15, 2020; 86 FR 2967, Jan. 14, 2021; 87 FR 2333, Jan. 14, 2022]

§ 702.205 Employer's report; effect of failure to report upon time limitations.

Where the employer, or agent in charge of the business, or carrier has been given notice or has knowledge of an employee's injury or death, and fails, neglects, or refuses to file a report thereof as required by § 702.201, the time limitations provisions with respect to the filing of claims for compensation for disability or death (33 U.S.C. 913(a), and see § 702.221) shall not begin to run until such report shall have been furnished as required herein.

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 397, Jan. 3, 1985]

NOTICE

§ 702.211 Notice of employee's injury or death; designation of responsible official.

(a) In order to claim compensation under the Act, an employee or claimant must first give notice of the fact of an injury or death to the employer and also may give notice to the district director for the compensation district in which the injury or death occurred. Notice to the employer must be given to that individual whom the employer has designated to receive such notices. If no individual has been so designated notice may be given to: (1) The first line supervisor (including foreman, hatchboss or timekeeper), local plant manager or personnel office official; (2) to any partner if the employer is a partnership; or (3) if the employer is a corporation, to any authorized agent, to an officer or to the person in charge of the business at the place where the injury occurred. In the case of a retired employee, the employee/claimant may submit the notice to any of the above persons, whether or not the employer has designated an official to receive such notice.

(b) In order to facilitate the filing of notices, each employer shall designate at least one individual responsible for receiving notices of injury or death; this requirement applies to all employers. The designation shall be by position and the employer shall provide the name and/or position, exact location and telephone number of the individual to all employees by the appropriate method described below.

(1) *Type of individual.* Designees must be a first line supervisor (including a foreman, hatchboss or timekeeper), local plant manager, personnel office official, company nurse or other individual traditionally entrusted with this duty, who is located full-time on the premises of the covered facility. The employer must designate at least one individual at each place of employment or one individual for each work crew where there is no fixed place of employment (in that case, the designation should always be the same position for all work crews).

(2) *How designated.* The name and/or title, the location and telephone number of the individual who is selected by the employer to receive all notices shall be given to the district director for the compensation district in which the facility is located; posting on the worksite in a conspicuous place shall fulfill this requirement. A redesignation shall be effected by a change in posting.

(3) *Publication.* Every employer shall post the name and/or position, the exact location and telephone number of the designated official. The posting shall be part of the general posting requirement, done on a form prescribed by the Director, and placed in a conspicuous location. Posting must be done at each worksite.

(4) *Effect of failure to designate.* Where an employer fails to properly designate and to properly publish the name and/or position of the individual authorized to receive notices of injury or death, such failure shall constitute satisfactory reasons for excusing the employee/claimant's failure to give notice as authorized by section 12(d)(3)(ii) of the Act, 33 U.S.C. 912(d)(3)(ii).

(Approved by the Office of Management and Budget under control number 1215–0160)

[50 FR 397, Jan. 3, 1985, as amended at 51 FR 4283, Feb. 3, 1986]

§ 702.212 Notice; when given; when given for certain occupational diseases.

(a) For other than occupational diseases described in (b), the employee must give notice within thirty (30) days of the date of the injury or death. For this purpose the date of injury or death is:

(1) The day on which a traumatic injury occurs;

(2) The date on which the employee or claimant is or by the exercise of reasonable diligence or by reason of medical advice, should have been aware of a relationship between the injury or death and the employment; or

(3) In the case of claims for loss of hearing, the date the employee receives an audiogram, with the accompanying report which indicates the employee has suffered a loss of hearing that is related to his or her employment. (See § 702.441).

(b) In the case of an occupational disease which does not immediately result in disability or death, notice must be given within one year after the employee or claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice, should have been aware, of the relationship between the employment, the disease and the death or disability. For purposes of these occupational diseases, therefore, the notice period does not begin to run until the employee is disabled, or in the case of a retired employee, until a permanent impairment exists.

(c) For purposes of workers whose coverage under this Act is dependent on denial of coverage under a State compensation program, as described in § 701.401, the time limitations set forth above do not begin to run until a final decision denying State coverage is issued under the State compensation act.

(Approved by the Office of Management and Budget under control number 1215–0160)

[50 FR 397, Jan. 3, 1985, as amended at 51 FR 4283, Feb. 3, 1986]

§ 702.213 Notice; by whom given.

Notice shall be given by the injured employee or someone on his behalf, or in the case of death, by the deceased employee's beneficiary or someone on his behalf.

[38 FR 26861, Sept. 26, 1973. Redesignated at 50 FR 397, Jan. 3, 1985]

§ 702.214 Notice; form and content.

Notice shall be in writing on a form prescribed by the Director for this purpose; such form shall be made available to the employee or beneficiary by the employer. The notice shall be signed by the person authorized to give notice, and shall contain the name, address and Social Security Number (SSN) of the employee and, in death cases, also the SSN of the person seeking survivor benefits, and a statement of the time, place, nature and cause of the injury or death.

[58 FR 68032, Dec. 23, 1993]

§ 702.215 Notice; how given.

Notice must be effected by delivering it to the individual designated to receive such notices at the physical or electronic address designated by the employer. Notice may be given to the district director by submitting a copy of the form supplied by OWCP to the district director, or orally in person or by telephone.

[80 FR 12929, Mar. 12, 2015]

§ 702.216 Effect of failure to give notice.

Failure to give timely notice to the employer's designated official shall not bar any claim for compensation if: (a) The employer, carrier, or designated official had actual knowledge of the injury or death; or (b) the district director or ALJ determines the employer or carrier has not been prejudiced: or (c)

the district director excuses failure to file notice. For purposes of this subsection, actual knowledge shall be deemed to exist if the employee's immediate supervisor was aware of the injury and/or in the case of a hearing loss, where the employer has furnished to the employee an audiogram and report which indicates a loss of hearing. Failure to give notice shall be excused by the district director if: a) Notice, while not given to the designated official, was given to an official of the employer or carrier, and no prejudice resulted; or b) for some other satisfactory reason, notice could not be given. Failure to properly designate and post the individual so designated shall be considered a satisfactory reason. In any event, such defense to a claim must be raised by the employer/carrier at the first hearing on the claim.

[51 FR 4283, Feb. 3, 1986]

§ 702.217 Penalty for false statement, misrepresentation.

(a) 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.

(b) Any person including, but not limited to, an employer, its duly authorized agent or an employee of an insurance carrier, who knowingly and willingly makes a false statement or representation for the purpose of reducing, denying or terminating benefits to an injured employee, or his dependents pursuant to section 9, 33 U.S.C. 909, if the injury results in death, shall be punished by a fine not to exceed $10,000, by imprisonment not to exceed five years, or both.

[50 FR 398, Jan. 3, 1985]

CLAIMS

§ 702.221 Claims for compensation; time limitations.

(a) Claims for compensation for disability or death shall be in writing and filed with the district director for the compensation district in which the injury or death occurred. The Social Security Number (SSN) of the injured employee and, in cases of death, the SSN of the person seeking survivor benefits shall also be set forth on each claim. Claims may be filed anytime after the seventh day of disability or anytime following the death of the employee. Except as provided below, the right to compensation is barred unless a claim is filed within one year of the injury or death, or (where payment is made without an award) within one year of the date on which the last compensation payment was made.

(b) In the case of a hearing loss claim, the time for filing a claim does not begin to run until the employee receives an audiogram with the accompanying report which indicates the employee has sustained a hearing loss that is related to his or her employment. (See § 702.441).

(Approved by the Office of Management and Budget under control number 1215–0160)

[50 FR 398, Jan. 3, 1985, as amended at 51 FR 4284, Feb. 3, 1986; 58 FR 68032, Dec. 23, 1993]

§ 702.222 Claims; exceptions to time limitations.

(a) Where a person entitled to compensation under the Act is mentally incompetent or a minor, the time limitation provision of § 702.221 shall not apply to a mentally incompetent person so long as such person has no guardian or other authorized representative, but § 702.221 shall be applicable from the date of appointment of such guardian or other representative. In the case of minor who has no guardian before he or she becomes of age, time begins to run from the date he or she becomes of age.

(b) Where a person brings a suit at law or in admiralty to recover damages in respect of an injury or death, or files a claim under a State workers' compensation act because such person is excluded from this Act's coverage by reason of section 2(3) or 3(d) of the Act (33 U.S.C. 902(3) or 903(d)), and recovery is denied because the person was an employee and defendant was an employer within the meaning of the Act, and such employer had secured compensation to such employee under the Act, the time limitation in § 702.221

shall not begin to run until the date of termination of such suit or proceeding.

(c) Notwithstanding the provisions in paragraph (a) of this section, where the claim is one based on disability or death due to an occupational disease which does not immediately result in death or disability, it must be filed within two years after the employee or claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice, should have been aware of the relationship between the employment, the disease and the death or disability, or within one year of the date of last payment of compensation, whichever is later. For purposes of occupational disease, therefore, the time limitation for filing a claim does not begin to run until the employee is disabled, or in the case of a retired employee, where a permanent impairment exists.

(d) The time limitations set forth above do not apply to claims filed under section 49 of the Act, 33 U.S.C. 949.

(Approved by the Office of Management and Budget under control number 1215–0160)

[50 FR 398, Jan. 3, 1985]

§ 702.223 Claims; time limitations; time to object.

Notwithstanding the requirements of § 702.221, failure to file a claim within the period prescribed in such section shall not be a bar to such right unless objection to such failure is made at the first hearing of such claim in which all parties in interest are given reasonable notice and opportunity to be heard.

[38 FR 26861, Sept. 26, 1973. Redesignated and amended at 50 FR 397, Jan. 3, 1985]

§ 702.224 Claims; notification of employer of filing by employee.

Within 10 days after the filing of a claim for compensation for injury or death under the Act, the district director must give written notice thereof to the employer or carrier.

[80 FR 12929, Mar. 12, 2015]

§ 702.225 Withdrawal of a claim.

(a) *Before adjudication of claim.* A claimant (or an individual who is authorized to execute a claim on his behalf) may withdraw his previously filed claim: *Provided*, That:

(1) He files with the district director with whom the claim was filed a written request stating the reasons for withdrawal;

(2) The claimant is alive at the time his request for withdrawal is filed;

(3) The district director approves the request for withdrawal as being for a proper purpose and in the claimant's best interest; and

(4) The request for withdrawal is filed, on or before the date the OWCP makes a determination on the claim.

(b) *After adjudication of claim.* A claim for benefits may be withdrawn by a written request filed after the date the OWCP makes a determination on the claim: *Provided*, That:

(1) The conditions enumerated in paragraphs (a) (1) through (3) of this section are met; and

(2) There is repayment of the amount of benefits previously paid because of the claim that is being withdrawn or it can be established to the satisfaction of the Office that repayment of any such amount is assured.

(c) *Effect of withdrawal of claim.* Where a request for withdrawal of a claim is filed and such request for withdrawal is approved, such withdrawal shall be without prejudice to the filing of another claim, subject to the time limitation provisions of section 13 of the Act and of the regulations in this part.

[38 FR 26861, Sept. 26, 1973. Redesignated at 50 FR 397, Jan. 3, 1985]

NONCONTROVERTED CLAIMS

§ 702.231 Noncontroverted claims; payment of compensation without an award.

Unless the employer controverts its liability to pay compensation under this Act, the employer or insurance carrier shall pay periodically, promptly and directly to the person entitled thereto benefits prescribed by the Act. For this purpose, where the employer furnishes to an employee a copy of an audiogram with a report thereon, which indicates the employee has sustained a hearing loss causally related to factors of that employment, the employer or insurance carrier shall pay

appropriate compensation or at that time controvert the liability to pay compensation under this Act.

[50 FR 399, Jan. 3, 1985]

§ 702.232 Payments without an award; when; how paid.

The first installment of compensation shall become due by the fourteenth (14th) day after the employer has been notified, through the designated official or by any other means described in § 702.211 *et seq.*, or has actual knowledge of the injury or death. All compensation due on that fourteenth (14th) day shall be paid then and appropriate compensation due thereafter must be paid in semi-monthly installments, unless the district director determines otherwise.

[50 FR 399, Jan. 3, 1985]

§ 702.233 Penalty for failure to pay without an award.

If any installment of compensation payable without an award is not paid within 14 days after it becomes due, there shall be added to such unpaid installment an amount equal to 10 per centum thereof which shall be paid at the same time as, but in addition to, such installment unless the employer files notice of controversion in accordance with § 702.261, or unless such nonpayment is excused by the district director after a showing by the employer that owing to conditions over which he had no control such installment could not be paid within the period prescribed for the payment.

§ 702.234 Report by employer of commencement and suspension of payments.

Immediately upon making the first payment of compensation, and upon the suspension of payments once begun, the employer must notify the district director who is administering the claim of the commencement or suspension of payments, as the case may be.

[80 FR 12929, Mar. 12, 2015]

§ 702.235 Report by employer of final payment of compensation.

(a) Within 16 days after the final payment of compensation has been made, the employer, the insurance carrier, or where the employer is self-insured, the employer shall notify the district director on a form prescribed by the Secretary, stating that such final payment has been made, the total amount of compensation paid, the name and address of the person(s) to whom payments were made, the date of the injury or death and the name of the injured or deceased employee, and the inclusive dates during which compensation was paid.

(b) A ''final payment of compensation'' for the purpose of applying the penalty provision of § 702.236 shall be deemed any one of the following:

(1) The last payment of compensation made in accordance with a compensation order awarding disability or death benefits, issued by either a district director or an administrative law judge;

(2) The payment of an agreed settlement approved under section 8(i) (A) or (B), of the Act, 33 U.S.C. 908(i);

(3) The last payment made pursuant to an agreement reached by the parties through informal proceedings;

(4) Any other payment of compensation which anticipates no further payments under the Act.

(Approved by the Office of Management and Budget under control number 1215–0024)

(Pub. L. No. 96–511)

[42 FR 45302, Sept. 9, 1977, as amended at 49 FR 18294, Apr. 30, 1984; 50 FR 399, Jan. 3, 1985]

§ 702.236 Penalty for failure to report termination of payments.

Any employer failing to notify the district director that the final payment of compensation has been made as required by § 702.235 shall be assessed a civil penalty in the amount of $320 for any violation for which penalties are assessed after January 15, 2022. The district director has the authority and responsibility for assessing a civil penalty under this section.

[81 FR 43449, July 1, 2016, as amended at 82 FR 5380, Jan. 18, 2017; 83 FR 11, Jan. 2, 2018; 84 FR 217, Jan. 23, 2019; 85 FR 2296, Jan. 15, 2020; 86 FR 2967, Jan. 14, 2021; 87 FR 2333, Jan. 14, 2022]

AGREED SETTLEMENTS

§ 702.241 Definitions and supplementary information.

(a) As used hereinafter, the term *adjudicator* shall mean district director or administrative law judge (ALJ).

(b) If a settlement application is submitted to an adjudicator and the case is pending at the Office of Administrative Law Judges, the Benefits Review Board, or any Federal circuit court of appeals, the parties may request that the case be remanded to the adjudicator for consideration of the application. The thirty day period as described in paragraph (f) of this section begins when the remanded case is received by the adjudicator.

(c) If a settlement application is first submitted to an ALJ, the thirty day period mentioned in paragraph (f) of this section does not begin until five days before the date the formal hearing is set. This rule does not preclude the parties from submitting the application at any other time such as (1) after the case is referred for hearing, (2) at the hearing, or (3) after the hearing but before the ALJ issues a decision and order. Where a case is pending before the ALJ but not set for a hearing, the parties may request the case be remanded to the district director for consideration of the settlement.

(d) A settlement agreement between parties represented by counsel, which is deemed approved when not disapproved within thirty days, as described in paragraph (f) of this section, shall be considered to have been filed in the office of the district director on the thirtieth day for purposes of sections 14 and 21 of the Act, 33 U.S.C. 914 and 921.

(e) A fee for representation which is included in an agreement that is approved in the manner described in paragraph (d) of this section, shall also be considered approved within the meaning of section 28(e) of the Act, 33 U.S.C. 928(e).

(f) The thirty day period for consideration of a settlement agreement shall be calculated from the day after receipt unless the parties are advised otherwise by the adjudicator. (See § 702.243(b)). If the last day of this period is a holiday or occurs during a weekend, the next business day shall be considered the thirtieth day.

(g) An agreement among the parties to settle a claim is limited to the rights of the parties and to claims then in existence; settlement of disability compensation or medical benefits shall not be a settlement of survivor benefits nor shall the settlement affect, in any way, the right of survivors to file a claim for survivor's benefits.

(h) For purposes of this section and § 702.243 the term *counsel* means any attorney admitted to the bar of any State, territory or the District of Columbia.

[50 FR 399, Jan. 3, 1985, as amended at 51 FR 4284, Feb. 3, 1986]

§ 702.242 Information necessary for a complete settlement application.

(a) The settlement application shall be a self-sufficient document which can be evaluated without further reference to the administrative file. The application shall be in the form of a stipulation signed by all parties and shall contain a brief summary of the facts of the case to include: a description of the incident, a description of the nature of the injury to include the degree of impairment and/or disability, a description of the medical care rendered to date of settlement, and a summary of compensation paid and the compensation rate or, where benefits have not been paid, the claimant's average weekly wage.

(b) The settlement application shall contain the following:

(1) A full description of the terms of the settlement which clearly indicates, where appropriate, the amounts to be paid for compensation, medical benefits, survivor benefits and representative's fees which shall be itemized as required by § 702.132.

(2) The reason for the settlement, and the issues which are in dispute, if any.

(3) The claimant's date of birth and, in death claims, the names and birth dates of all dependents.

(4) Information on whether or not the claimant is working or is capable of working. This should include, but not be limited to, a description of the claimant's educational background and work history, as well as other factors

which could impact, either favorably or unfavorably, on future employability.

(5) A current medical report which fully describes any injury related impairment as well as any unrelated conditions. This report shall indicate whether maximum medical improvement has been reached and whether further disability or medical treatment is anticipated. If the claimant has already reached maximum medical improvement, a medical report prepared at the time the employee's condition stabilized will satisfy the requirement for a current medical report. A medical report need not be submitted with agreements to settle survivor benefits unless the circumstances warrant it.

(6) A statement explaining how the settlement amount is considered adequate.

(7) If the settlement application covers medical benefits an itemization of the amount paid for medical expenses by year for the three years prior to the date of the application. An estimate of the claimant's need for future medical treatment as well as an estimate of the cost of such medical treatment shall also be submitted which indicates the inflation factor and/or the discount rate used, if any. The adjudicator may waive these requirements for good cause.

(8) Information on any collateral source available for the payment of medical expenses.

(Approved by the Office of Management and Budget under control number 1215–0160)

[50 FR 399, Jan. 3, 1985, as amended at 51 FR 4284, Feb. 3, 1986]

§ 702.243 Settlement application; how submitted, how approved, how disapproved, criteria.

(a) When the parties to a claim for compensation, including survivor benefits and medical benefits, agree to a settlement they must submit a complete application to the adjudicator. The application must contain all the information outlined in § 702.242 and must be sent by certified mail with return receipt requested, commercial delivery service with tracking capability that provides reliable proof of delivery to the adjudicator, or electronically through an OWCP-authorized system. Failure to submit a complete application will toll the thirty day period mentioned in section 8(i) of the Act, 33 U.S.C. 908(i), until a complete application is received.

(b) The adjudicator must consider the settlement application within thirty days and either approve or disapprove the application. The liability of an employer/insurance carrier is not discharged until the settlement is specifically approved by a compensation order issued by the adjudicator. However, if the parties are represented by counsel, the settlement will be deemed approved unless specifically disapproved within thirty days after receipt of a complete application. This thirty day period does not begin until all the information described in § 702.242 has been submitted. The adjudicator will examine the settlement application within thirty days and must immediately serve on all parties notice of any deficiency. This notice must also indicate that the thirty day period will not commence until the deficiency is corrected.

(c) If the adjudicator disapproves a settlement application, the adjudicator must serve on all parties a written statement or order containing the reasons for disapproval. This statement must be served within thirty days of receipt of a complete application (as described in § 702.242) if the parties are represented by counsel. If the disapproval was made by a district director, any party to the settlement may request a hearing before an ALJ as provided in sections 8 and 19 of the Act, 33 U.S.C. 908 and 919, or an amended application may be submitted to the district director. If, following the hearing, the ALJ disapproves the settlement, the parties may: (1) Submit a new application, (2) file an appeal with the Benefits Review Board as provided in section 21 of the Act, 33 U.S.C. 921, or (3) proceed with a hearing on the merits of the claim. If the application is initially disapproved by an ALJ, the parties may (1) submit a new application or (2) proceed with a hearing on the merits of the claim.

(d) The parties may submit a settlement application solely for compensation, or solely for medical benefits or for compensation and medical benefits combined.

(e) If either portion of a combined compensation and medical benefits settlement application is disapproved the entire application is disapproved unless the parties indicate on the face of the application that they agree to settle either portion independently.

(f) When presented with a settlement, the adjudicator must review the application and determine whether, considering all of the circumstances, including, where appropriate, the probability of success if the case were formally litigated, the amount is adequate. The criteria for determining the adequacy of the settlement application will include, but not be limited to:

(1) The claimant's age, education and work history;

(2) The degree of the claimant's disability or impairment;

(3) The availability of the type of work the claimant can do;

(4) The cost and necessity of future medical treatment (where the settlement includes medical benefits).

(g) In cases being paid pursuant to a final compensation order, where no substantive issues are in dispute, a settlement amount which does not equal the present value of future compensation payments commuted, computed at the discount rate specified below, must be considered inadequate unless the parties to the settlement show that the amount is adequate. The probability of the death of the beneficiary before the expiration of the period during which he or she is entitled to compensation will be determined according to the most current United States Life Table, as developed by the United States Department of Health and Human Services, which will be updated from time to time. The discount rate will be equal to the coupon issue yield equivalent (as determined by the Secretary of the Treasury) of the average accepted auction price for the last auction of 52 weeks U.S. Treasury Bills settled immediately prior to the date of the submission of the settlement application.

[50 FR 399, Jan. 3, 1985, as amended at 51 FR 4284, Feb. 3, 1986; 60 FR 51348, Oct. 2, 1995; 80 FR 12929, Mar. 12, 2015]

CONTROVERTED CLAIMS

§ 702.251 Employer's controversion of the right to compensation.

Where the employer controverts the right to compensation after notice or knowledge of the injury or death, or after receipt of a written claim, he must give notice thereof, stating the reasons for controverting the right to compensation, using the form prescribed by the Director. Such notice, or answer to the claim, must be filed with the district director within 14 days from the date the employer receives notice or has knowledge of the injury or death. A copy of the notice must also be given to the claimant.

[80 FR 12929, Mar. 12, 2015]

§ 702.252 Action by district director upon receipt of notice of controversion.

Upon receiving the employer's notice of controversion, the district director shall forthwith commence proceedings for the adjudication of the claim in accordance with the procedures set forth in subpart C of this part.

CONTESTED CLAIMS

§ 702.261 Claimant's contest of actions taken by employer or carrier with respect to the claim.

Where the claimant contests an action by the employer or carrier reducing, suspending, or terminating benefits, including medical care, he should immediately notify the office of the district director who is administering the claim and set forth the facts pertinent to his complaint.

[80 FR 12929, Mar. 12, 2015]

§ 702.262 Action by district director upon receipt of notice of contest.

Upon receipt of the claimant's notice of contest, the district director shall forthwith commence proceedings for adjudication of the claim in accordance with the procedures set forth in subpart C of this part.

DISCRIMINATION

§ 702.271 Discrimination; against employees who bring proceedings, prohibition and penalty.

(a)(1) No employer or its duly authorized agent may discharge or in any manner discriminate against an employee as to his/her employment because that employee: (i) Has claimed or attempted to claim compensation under this Act; or (ii) has testified or is about to testify in a proceeding under this Act. To discharge or refuse to employ a person who has been adjudicated to have filed a fraudulent claim for compensation or otherwise made a false statement or misrepresentation under section 31(a)(1) of the Act, 33 U.S.C. 931(a)(1), is not a violation of this section.

(2) Any employer who violates this section, and has penalties assessed for such violation after January 15, 2022, shall be liable for a penalty of not less than $2,627 or more than $13,132 to be paid (by the employer alone, and not by a carrier) to the district director for deposit in the special fund described in section 44 of the Act, 33 U.S.C. 944; and shall restore the employee to his or her employment along with all wages lost due to the discrimination unless the employee has ceased to be qualified to perform the duties of employment.

(b) When a district director receives a complaint from an employee alleging discrimination as defined under section 49, he or she shall notify the employer, and within five working days, initiate specific inquiry to determine all the facts and circumstances pertaining thereto. This may be accomplished by interviewing the employee, employer representatives and other parties who may have information about the matter. Interviews may be conducted by written correspondence, telephone or personal interview.

(c) If circumstances warrant, the district director may also conduct an informal conference on the issue as described in §§ 702.312 through 702.314.

(d) Any employee discriminated against is entitled to be restored to his employment and to be compensated by the employer for any loss of wages arising out of such discrimination provided that the employee is qualified to perform the duties of the employment. If it is determined that the employee has been discriminated against, the district director shall also determine whether the employee is qualified to perform the duties of the employment. The district director may use medical evidence submitted by the parties or he may arrange to have the employee examined by a physician selected by the district director. The cost of the medical examination arranged for by the district director may be charged to the special fund established by section 44, 33 U.S.C. 944.

[42 FR 45302, Sept. 9, 1977, as amended at 50 FR 400, Jan. 3, 1985; 62 FR 53956, Oct. 17, 1997; 81 FR 43449, July 1, 2016; 82 FR 5380, Jan. 18, 2017; 83 FR 11, Jan. 2, 2018; 84 FR 217, Jan. 23, 2019; 85 FR 2296, Jan. 15, 2020; 86 FR 2967, Jan. 14, 2021; 87 FR 2333, Jan. 14, 2022]

§ 702.272 Informal recommendation by district director.

(a) If the district director determines that the employee has been discharged or suffered discrimination and is able to resume his or her duties, the district director will recommend that the employer reinstate the employee and/or make such restitution as is indicated by the circumstances of the case, including compensation for any wage loss suffered as the result of the discharge or discrimination. The district director may also assess the employer an appropriate penalty, as determined under authority vested in the district director by the Act. If the district director determines that no violation occurred he must notify the parties of his findings and the reasons for recommending that the complaint be denied. If the employer and employee accept the district director's recommendation, within 10 days it will be incorporated in an order, to be filed and served in accordance with § 702.349.

(b) If the parties do not agree to the recommendation, the district director must, within 10 days after receipt of the rejection, prepare a memorandum summarizing the disagreement, send a copy to all interested parties, and within 14 days thereafter, refer the

case to the Office of the Chief Administrative Law Judge for hearing pursuant to § 702.317.

[42 FR 45302, Sept. 9, 1977, as amended at 80 FR 12929, Mar. 12, 2015]

§ 702.273 Adjudication by Office of the Chief Administrative Law Judge.

The Office of Administrative Law Judges is responsible for final determinations of all disputed issues connected with the discrimination complaint, including the amount of penalty to be assessed, and shall proceed with a formal hearing as described in §§ 702.331 to 702.394.

[42 FR 45302, Sept. 9, 1977]

§ 702.274 Employer's refusal to pay penalty.

In the event the employer refuses to pay the penalty assessed, the district director shall refer the complete administrative file to the Associate Director, Division of Longshore and Harbor Workers' Compensation, for subsequent transmittal to the Associate Solicitor for Employee Benefits, with the request that appropriate legal action be taken to recover the penalty.

[42 FR 45302, Sept. 9, 1977]

THIRD PARTY

§ 702.281 Third party action.

(a) Every person claiming benefits under this Act (or the representative) must promptly notify the employer and the district director when:

(1) A claim is made that someone other than the employer or person or persons in its employ, is liable in damages to the claimant because of the injury or death and identify such party by name and address.

(2) Legal action is instituted by the claimant or the representative against some person or party other than the employer or a person or persons in his employ, on the ground that such other person is liable in damages to the claimant on account of the compensable injury and/or death; specify the amount of damages claimed and identify the person or party by name and address.

(3) Any settlement, compromise or any adjudication of such claim has been effected and report the terms, conditions and amounts of such resolution of claim.

(b) Where the claim or legal action instituted against a third party results in a settlement agreement which is for an amount less than the compensation to which a person would be entitled under this Act, the person (or the person's representative) must obtain the prior, written approval of the settlement from the employer and the employer's carrier before the settlement is executed. Failure to do so relieves the employer and/or carrier of liability for compensation described in section 33(f) of Act, 33 U.S.C. 933(f) and for medical benefits otherwise due under section 7 of the Act, 33 U.S.C. 907, regardless of whether the employer or carrier has made payments of acknowledged entitlement to benefits under the Act. The approval must be on a form provided by OWCP and must be filed, within thirty days after the settlement is entered into, with the district director who is administering the claim.

[42 FR 45303, Sept. 9, 1977, as amended at 50 FR 400, Jan. 3, 1985; 51 FR 4284, Feb. 3, 1986; 80 FR 12930, Mar. 12, 2015]

REPORT OF EARNINGS

§ 702.285 Report of earnings.

(a) An employer, carrier or the Director (for those cases being paid from the Special Fund) may require an employee to whom it is paying compensation to submit a report on earnings from employment or self-employment. This report may not be required any more frequently than semi-annually. The report shall be made on a form prescribed by the Director and shall include all earnings from employment and self-employment and the periods for which the earnings apply. The employee must return the complete report on earnings even where he or she has no earnings to report.

(b) For these purposes the term ''earnings'' is defined as all monies received from any employment and includes but is not limited to wages, salaries, tips, sales commissions, fees for services provided, piecework and all revenue received from self-employment

even if the business or enterprise operated at a loss of if the profits were reinvested.

(Approved by the Office of Management and Budget under control number 1215–0160)

[50 FR 400, Jan. 3, 1985]

§ 702.286 Report of earnings; forfeiture of compensation.

(a) Any employee who fails to submit the report on earnings from employment or self-employment under § 702.285 or, who knowingly and willingly omits or understates any part of such earnings, shall upon a determination by the district director forfeit all right to compensation with respect to any period during which the employee was required to file such a report. The employee must return the completed report on earnings (even where he or she reports no earnings) within thirty (30) days of the date of receipt; this period may be extended for good cause, by the district director, in determining whether a violation of this requirement has occurred.

(b) Any employer or carrier who believes that a violation of paragraph (a) of this section has occurred may file a charge with the district director. The allegation shall be accompanied by evidence which includes a copy of the report, with proof of service requesting the information from the employee and clearly stating the dates for which the employee was required to report income. Where the employer/carrier is alleging an omission or understatement of earnings, it shall, in addition, present evidence of earnings by the employee during that period, including copies of checks, affidavits from employers who paid the employee earnings, receipts of income from self-employment or any other evidence showing earnings not reported or underreported for the period in question. Where the district director finds the evidence sufficient to support the charge he or she shall convene an informal conference as described in subpart C and shall issue a compensation order affiming or denying the charge and setting forth the amount of compensation for the specified period. If there is a conflict over any issue relating to this matter any party may request a formal hearing before an Administrative Law Judge as described in subpart C.

(c) Compensation forfeited under paragraph (b) of this section, if already paid, shall be recovered by a deduction from the compensation payable to the employee if any, on such schedule as determined by the district director. The district director's discretion in such cases extends only to rescheduling repayment by crediting future compensation and not to whether and in what amounts compensation is forfeited. For this purpose, the district director shall consider the employee's essential expenses for living, income from whatever source, and assets, including cash, savings and checking accounts, stocks, bonds, and other securities.

[50 FR 400, Jan. 3, 1985]

Subpart C—Adjudication Procedures

GENERAL

§ 702.301 Scope of this subpart.

The regulations in this subpart govern the adjudication of claims in which the employer has filed a notice of controversion under § 702.251, or the employee has filed notice of contest under § 702.261. In the vast majority of cases, the problem giving rise to the controversy results from misunderstandings, clerical or mechanical errors, or mistakes of fact or law. Such problems seldom require resolution through formal hearings, with the attendant production of expert witnesses. Accordingly, by § 702.311 *et seq.*, the district directors are empowered to amicably and promptly resolve such problems by informal procedures. Where there is a genuine dispute of fact or law which cannot be so disposed of informally, resort must be had to the formal hearing procedures as set forth beginning at § 702.331. Supplementary compensation orders, modifications, and interlocutory matters are governed by regulations beginning with § 702.371. Thereafter, appeals from compensation orders are discussed beginning with § 702.391 (the regulations of the Benefits Review Board are set forth in full in part 802 of this title).

ACTION BY DISTRICT DIRECTORS

§ 702.311 Handling of claims matters by district directors; informal conferences.

The district director is empowered to resolve disputes with respect to claims in a manner designed to protect the rights of the parties and also to resolve such disputes at the earliest practicable date. This will generally be accomplished by informal discussions by telephone or by conferences at the district director's office. Some cases will be handled by written correspondence. The regulations governing informal conferences at the district director's office with all parties present are set forth below. When handling claims by telephone, or at the office with only one of the parties, the district director and his staff shall make certain that a full written record be made of the matters discussed and that such record be placed in the administrative file. When claims are handled by correspondence, copies of all communications shall constitute the administrative file.

§ 702.312 Informal conferences; called by and held before whom.

Informal conferences shall be called by the district director or his designee assigned or reassigned the case and held before that same person, unless such person is absent or unavailable. When so assigned, the designee shall perform the duties set forth below assigned to the district director, except that a compenstion order following an agreement shall be issued only by a person so designated by the Director to perform such duty.

[42 FR 45303, Sept. 9, 1977]

§ 702.313 Informal conferences; how called; when called.

Informal conferences may be called upon not less than 10 days' notice to the parties, unless the parties agree to meet at an earlier date. The notice may be given by telephone, but shall be confirmed by use of a written notice on a form prescribed by the Director. The notice shall indicate the date, time and place of the conference, and shall also specify the matters to be discussed. For good cause shown conferences may be rescheduled. A copy of such notice shall be placed in the administrative file.

§ 702.314 Informal conferences; how conducted; where held.

(a) No stenographic report shall be taken at informal conferences and no witnesses shall be called. The district director shall guide the discussion toward the achievement of the purpose of such conference, recommending courses of action where there are disputed issues, and giving the parties the benefit of his experience and specialized knowledge in the field of workmen's compensation.

(b) Conferences generally shall be held at the district director's office. However, such conferences may be held at any place which, in the opinion of the district director, will be of greater convenience to the parties or to their representatives.

§ 702.315 Conclusion of conference; agreement on all matters with respect to the claim.

(a) Following an informal conference at which agreement is reached on all issues, the district director must (within 10 days after conclusion of the conference), embody the agreement in a memorandum or within 30 days issue a formal compensation order, to be filed and served in accordance with § 702.349. If either party requests that a formal compensation order be issued, the district director must, within 30 days of such request, prepare, file, and serve such order in accordance with § 702.349. Where the problem was of such nature that it was resolved by telephone discussion or by exchange of written correspondence, the district director must prepare a memorandum or order setting forth the terms agreed upon and notify the parties either by telephone or in writing, as appropriate. In either instance, when the employer or carrier has agreed to pay, reinstate or increase monetary compensation benefits, or to restore or appropriately change medical care benefits, such action must be commenced immediately upon becoming aware of the agreement, and without awaiting receipt of the memorandum or the formal compensation order.

(b) Where there are several conferences or discussions, the provisions of paragraph (a) of this section do not apply until the last conference. The district director must, however, prepare and place in his administrative file a short, succinct memorandum of each preceding conference or discussion.

[80 FR 12930, Mar. 12, 2015]

§ 702.316 Conclusion of conference; no agreement on all matters with respect to the claim.

When it becomes apparent during the course of the informal conference that agreement on all issues cannot be reached, the district director shall bring the conference to a close, shall evaluate all evidence available to him or her, and after such evaluation shall prepare a memorandum of conference setting forth all outstanding issues, such facts or allegations as appear material and his or her recommendations and rationale for resolution of such issues. Copies of this memorandum shall then be sent to each of the parties or their representatives, who shall then have 14 days within which to signify in writing to the district director whether they agree or disagree with his or her recommendations. If they agree, the district director shall proceed as in § 702.315(a). If they disagree (Caution: See § 702.134), then the district director may schedule such further conference or conferences as, in his or her opinion, may bring about agreement; if he or she is satisfied that any further conference would be unproductive, or if any party has requested a hearing, the district director shall prepare the case for transfer to the Office of the Chief Administrative Law Judge (See § 702.317, §§ 702.331–702.351).

[42 FR 42551, Aug. 23, 1977, as amended at 60 FR 51348, Oct. 2, 1995]

§ 702.317 Preparation and transfer of the case for hearing.

A case is prepared for transfer in the following manner:

(a) The district director will furnish each of the parties or their representatives with a copy of a prehearing statement form.

(b) Each party must, within 21 days after receipt of such form, complete it and return it to the district director and serve copies on all other parties. Extensions of time for good cause may be granted by the district director.

(c) Upon receipt of the completed forms, the district director, after checking them for completeness and after any further conferences that, in his or her opinion, are warranted, will transmit them to the Office of the Chief Administrative Law Judge by letter of transmittal together with all available evidence which the parties intend to submit at the hearings (exclusive of X-rays, slides and other materials not suitable for transmission which may be offered into evidence at the time of the hearing); the materials transmitted must not include any recommendations expressed or memoranda prepared by the district director pursuant to § 702.316.

(d) If the completed pre-hearing statement forms raise new or additional issues not previously considered by the district director or indicate that material evidence will be submitted that could reasonably have been made available to the district director before he or she prepared the last memorandum of conference, the district director will transfer the case to the Office of the Chief Administrative Law Judge only after having considered such issues or evaluated such evidence or both and having issued an additional memorandum of conference in conformance with § 702.316.

(e) If a party fails to complete or return his or her pre-hearing statement form within the time allowed, the district director may, at his or her discretion, transmit the case without that party's form. However, such transmittal must include a statement from the district director setting forth the circumstances causing the failure to include the form, and such party's failure to submit a pre-hearing statement form may, subject to rebuttal at the formal hearing, be considered by the administrative law judge, to the extent intransigence is relevant, in subsequent rulings on motions which may be made in the course of the formal hearing.

[80 FR 12930, Mar. 12, 2015]

§ 702.318 The record; what constitutes; nontransferability of the administrative file.

For the purpose of any further proceedings under the Act, the formal record of proceedings shall consist of the hearing record made before the administrative law judge (see § 702.344). When transferring the case for hearing pursuant to § 702.317, the district director shall not transfer the administrative file under any circumstances.

§ 702.319 Obtaining documents from the administrative file for reintroduction at formal hearings.

Whenever any party considers any document in the administrative file essential to any further proceedings under the Act, it is the responsibility of such party to obtain such document from the district director and reintroduce it for the record before the administrative law judge. The type of document that may be obtained will be limited to documents previously submitted to the district director, including documents or forms with respect to notices, claims, controversions, contests, progress reports, medical services or supplies, etc. The work products of the district director or his staff will not be subject to retrieval. The procedure for obtaining documents will be for the requesting party to inform the district director in writing of the documents he wishes to obtain, specifying them with particularity. Upon receipt, the district director must promptly forward a copy of the requested materials to the requesting party. A copy of the letter of request and a statement of whether it has been satisfied must be kept in the case file.

[80 FR 12930, Mar. 12, 2015]

SPECIAL FUND

§ 702.321 Procedures for determining applicability of section 8(f) of the Act.

(a) *Application: filing, service, contents.* (1) An employer or insurance carrier which seeks to invoke the provisions of section 8(f) of the Act must request limitation of its liability and file a fully documented application with the district director. A fully documented application must contain a specific description of the pre-existing condition relied upon as constituting an existing permanent partial disability and the reasons for believing that the claimant's permanent disability after the injury would be less were it not for the pre-existing permanent partial disability or that the death would not have ensued but for that disability. These reasons must be supported by medical evidence as specified in this paragraph. The application must also contain the basis for the assertion that the pre-existing condition relied upon was manifest in the employer and documentary medical evidence relied upon in support of the request for section 8(f) relief. This medical evidence must include, but not be limited to, a current medical report establishing the extent of all impairments and the date of maximum medical improvement. If the claimant has already reached maximum medical improvement, a report prepared at that time will satisfy the requirement for a current medical report. If the current disability is total, the medical report must explain why the disability is not due solely to the second injury. If the current disability is partial, the medical report must explain why the disability is not due solely to the second injury and why the resulting disability is materially and substantially greater than that which would have resulted from the subsequent injury alone. If the injury is loss of hearing, the pre-existing hearing loss must be documented by an audiogram which complies with the requirements of § 702.441. If the claim is for survivor's benefits, the medical report must establish that the death was not due solely to the second injury. Any other evidence considered necessary for consideration of the request for section 8(f) relief must be submitted when requested by the district director or Director.

(2) If claim is being paid by the special fund and the claimant dies, an employer need not reapply for section 8(f) relief. However, survivor benefits will not be paid until it has been established that the death was due to the accepted injury and the eligible survivors have been identified. The district director will issue a compensation order

after a claim has been filed and entitlement of the survivors has been verified. Since the employer remains a party in interest to the claim, a compensation order will not be issued without the agreement of the employer.

(b) *Application: Time for filing.* (1) A request for section 8(f) relief should be made as soon as the permanency of the claimant's condition becomes known or is an issue in dispute. This could be when benefits are first paid for permanent disability, or at an informal conference held to discuss the permanency of the claimant's condition. Where the claim is for death benefits, the request should be made as soon as possible after the date of death. Along with the request for section 8(f) relief, the applicant must also submit all the supporting documentation required by this section, described in paragraph (a) of this section. Where possible, this documentation should accompany the request, but may be submitted separately, in which case the district director must, at the time of the request, fix a date for submission of the fully documented application. The date must be fixed as follows:

(i) Where notice is given to all parties that permanency will be an issue at an informal conference, the fully documented application must be submitted at or before the conference. For these purposes, notice means when the issue of permanency is noted on the form LS–141, Notice of Informal Conference. All parties are required to list issues reasonably anticipated to be discussed at the conference when the initial request for a conference is made and to notify all parties of additional issues which arise during the period before the conference is actually held.

(ii) Where the issue of permanency is first raised at the informal conference and could not have reasonably been anticipated by the parties prior to the conference, the district director must adjourn the conference and establish the date by which the fully documented application must be submitted and so notify the employer/carrier. The date will be set by the district director after reviewing the circumstances of the case.

(2) At the request of the employer or insurance carrier, and for good cause, the district director, at his/her discretion, may grant an extension of the date for submission of the fully documented application. In fixing the date for submission of the application under circumstances other than described above or in considering any request for an extension of the date for submitting the application, the district director must consider all the circumstances of the case, including but not limited to: Whether the claimant is being paid compensation and the hardship to the claimant of delaying referral of the case to the Office of Administrative Law Judges (OALJ); the complexity of the issues and the availability of medical and other evidence to the employer; the length of time the employer was or should have been aware that permanency is an issue; and, the reasons listed in support of the request. If the employer/carrier requested a specific date, the reasons for selection of that date will also be considered. Neither the date selected for submission of the fully documented application nor any extension therefrom can go beyond the date the case is referred to the OALJ for formal hearing.

(3) Where the claimant's condition has not reached maximum medical improvement and no claim for permanency is raised by the date the case is referred to the OALJ, an application need not be submitted to the district director to preserve the employer's right to later seek relief under section 8(f) of the Act. In all other cases, failure to submit a fully documented application by the date established by the district director will be an absolute defense to the liability of the special fund. This defense is an affirmative defense which must be raised and pleaded by the Director. The absolute defense will not be raised where permanency was not an issue before the district director. In all other cases, where permanency has been raised, the failure of an employer to submit a timely and fully documented application for section 8(f) relief will not prevent the district director, at his/her discretion, from considering the claim for compensation and transmitting the case for formal hearing. The failure of an employer to present a timely and fully documented application for section 8(f) relief may

be excused only where the employer could not have reasonably anticipated the liability of the special fund prior to the consideration of the claim by the district director. Relief under section 8(f) is not available to an employer who fails to comply with section 32(a) of the Act, 33 U.S.C. 932(a).

(c) *Application: Approval, disapproval.* If all the evidence required by paragraph (a) of this section was submitted with the application for section 8(f) relief and the facts warrant relief under this section, the district director must award such relief after concurrence by the Associate Director, DLHWC, or his or her designee. If the district director or the Associate Director or his or her designee finds that the facts do not warrant relief under section 8(f) the district director must advise the employer of the grounds for the denial. The application for section 8(f) relief may then be considered by an administrative law judge. When a case is transmitted to the Office of Administrative Law Judges the district director must also attach a copy of the application for section 8(f) relief submitted by the employer, and notwithstanding § 702.317(c), the district director's denial of the application.

(Approved by the Office of Management and Budget under control number 1215–0160)

[51 FR 4285, Feb. 3, 1986, as amended at 80 FR 12930, Mar. 12, 2015]

FORMAL HEARINGS

§ 702.331 Formal hearings; procedure initiating.

Formal hearings are initiated by transmitting to the Office of the Chief Administrative Law Judge the prehearing statement forms, the available evidence which the parties intend to submit at the formal hearing, and the letter of transmittal from the district director as provided in § 702.316 and § 702.317.

[42 FR 42552, Aug. 23, 1977]

§ 702.332 Formal hearings; how conducted.

Formal hearings shall be conducted by the administrative law judge assigned the case by the Office of the Chief Administrative Law Judge in accordance with the provisions of the Administrative Procedure Act, 5 U.S.C. 554 *et seq.* All hearings shall be transcribed.

§ 702.333 Formal hearings; parties.

(a) The necessary parties for a formal hearing are the claimant and the employer or insurance carrier, and the administrative law judge assigned the case.

(b) The Solicitor of Labor or his designee may appear and participate in any formal hearing held pursuant to these regulations on behalf of the Director as an interested party.

§ 702.334 Formal hearings; representatives of parties.

The claimant and the employer or carrier may be represented by persons of their choice.

§ 702.335 Formal hearings; notice.

On a form prescribed for this purpose, the Office of the Chief Administrative Law Judge shall notify the parties (See § 702.333) of the place and time of the formal hearing not less than 30 days in advance thereof.

[42 FR 42552, Aug. 23, 1977]

§ 702.336 Formal hearings; new issues.

(a) If, during the course of the formal hearing, the evidence presented warrants consideration of an issue or issues not previously considered, the hearing may be expanded to include the new issue. If in the opinion of the administrative law judge the new issue requires additional time for preparation, the parties shall be given a reasonable time within which to prepare for it. If the new issue arises from evidence that has not been considered by the district director, and such evidence is likely to resolve the case without the need for a formal hearing, the administrative law judge may remand the case to the district director for his or her evaluation and recommendation pursuant to, § 702.316.

(b) At any time prior to the filing of the compensation order in the case, the administrative law judge may in his discretion, upon the application of a party or upon his own motion, give notice that he will consider any new

issue. The parties shall be given not less than 10 days' notice of the hearing on such new issue. The parties may stipulate that the issue may be heard at an earlier time and shall proceed to a hearing on the new issue in the same manner as on an issue initially considered.

[38 FR 26861, Sept. 26, 1973, as amended at 42 FR 42552, Aug. 23, 1977]

§ 702.337 Formal hearings; change of time or place for hearings; postponements.

(a) Except for good cause shown, hearings shall be held at convenient locations not more than 75 miles from the claimant's residence.

(b) Once a formal hearing has been scheduled, continuances shall not be granted except in cases of extreme hardship or where attendance of a party or his or her representative is mandated at a previously scheduled judicial proceeding. Unless the ground for the request arises thereafter, requests for continuances must be received by the Chief Administrative Law Judge at least 10 days before the scheduled hearing date, must be served upon the other parties and must specify the extreme hardship or previously scheduled judicial proceeding claimed.

(c) The Chief Administrative Law Judge or the administrative law judge assigned to the case may change the time and place of the hearing, or temporarily adjourn a hearing, on his own motion or for good cause shown by a party. The parties shall be given not less than 10 days' notice of the new time and place of the hearing, unless they agree to such change without notice.

[42 FR 42552, Aug. 23, 1977]

§ 702.338 Formal hearings; general procedures.

All hearings shall be attended by the parties or their representatives and such other persons as the administrative law judge deems necessary and proper. The administrative law judge shall inquire fully into the matters at issue and shall receive in evidence the testimony of witnesses and any documents which are relevant and material to such matters. If the administrative law judge believes that there is relevant and material evidence available which has not been presented at the hearing, he may adjourn the hearing or, at any time, prior to the filing of the compensation order, reopen the hearing for the receipt of such evidence. The order in which evidence and allegations shall be presented and the procedures at the hearings generally, except as these regulations otherwise expressly provide, shall be in the discretion of the administrative law judge and of such nature as to afford the parties a reasonable opportunity for a fair hearing.

§ 702.339 Formal hearings; evidence.

In making an investigation or inquiry or conducting a hearing, the administrative law judge shall not be bound by common law or statutory rules of evidence or by technical or formal rules of procedure, except as provided by 5 U.S.C. 554 and these regulations; but may make such investigation or inquiry or conduct such hearing in such a manner as to best ascertain the rights of the parties.

§ 702.340 Formal hearings; witnesses.

(a) Witnesses at the hearing shall testify under oath or affirmation. The administrative law judge may examine the witnesses and shall allow the parties or their representatives to do so.

(b) No person shall be required to attend as a witness in any proceeding before an administrative law judge at a place more than 100 miles from his place of residence, unless his lawful mileage and fees for one day's attendance shall be paid or tendered to him in advance of the hearing date.

§ 702.341 Formal hearings; depositions; interrogatories.

The testimony of any witness, including any party represented by counsel, may be taken by deposition or interrogatory according to the Federal Rules of Civil Procedure as supplemented by local rules of practice for the Federal district court for the judicial district in which the case is pending. However, such depositions or interrogatories must be completed within reasonable times to be fixed by the Chief Administrative Law Judge or the

administrative law judge assigned to the case.

[42 FR 42552, Aug. 23, 1977]

§ 702.342 Formal hearings; witness fees.

Witnesses summoned in a formal hearing before an administrative law judge or whose depositions are taken shall receive the same fees and mileage as witnesses in courts of the United States (33 U.S.C. 925).

§ 702.343 Formal hearings; oral argument and written allegations.

Any party upon request shall be allowed a reasonable time for presentation of oral argument and shall be permitted to file a pre-hearing brief or other written statement of fact or law. A copy of any such pre-hearing brief or other written statement shall be filed with the Chief Administrative Law Judge or the administrative law judge assigned to the case before or during the proceeding at which evidence is submitted to the administrative law judge and shall be served upon each other party. Post-hearing briefs will not be permitted except at the request of the administrative law judge or upon averment on the record of a party that the case presents a specific novel or difficult legal or factual issue (or issues) that cannot be adequately addressed in oral summation. When permitted, any such brief shall be limited to the issue or issues specified by the administrative law judge or by the party in his or her averment and shall be due from any party desiring to address such issue or issues within 15 days of the conclusion of the proceeding at which evidence is submitted to the administrative law judge. Enlargement of the time for filing such briefs shall be granted only if the administrative law judge is persuaded that the brief will be helpful to him or her and that the enlargement granted will not delay decision of the case.

[42 FR 42552, Aug. 23, 1977]

§ 702.344 Formal hearings; record of hearing.

All formal hearings shall be open to the public and shall be stenographically reported. All evidence upon which the administrative law judge relies for his final decision shall be contained in the transcript of testimony either directly or by appropriate reference. All medical reports, exhibits, and any other pertinent document or record, in whole or in material part, shall be incorporated into the record either by reference or as an appendix.

§ 702.345 Formal hearings; consolidated issues; consolidated cases.

(a) When one or more additional issues are raised by the administrative law judge pursuant to § 702.336, such issues may, in the discretion of the administrative law judge, be consolidated for hearing and decision with other issues pending before him.

(b) When two or more cases are transferred for formal hearings and have common questions of law or which arose out of a common accident, the Chief Administrative Law Judge may consolidate such cases for hearing.

§ 702.346 Formal hearings; waiver of right to appear.

If all parties waive their right to appear before the administrative law judge or to present evidence or argument personally or by representative, it shall not be necessary for the administrative law judge to give notice of and conduct an oral hearing. A waiver of the right to appear and present evidence and allegations as to facts and law shall be made in writing and filed with the Chief Administrative Law Judge or the administrative law judge. Where such a waiver has been filed by all parties, and they do not appear before the administrative law judge personally or by representative, the administrative law judge shall make a record of the relevant written evidence submitted by the parties, together with any pleadings they may submit with respect to the issues in the case. Such documents shall be considered as all of the evidence in the case and the decision shall be based on them.

§ 702.347 Formal hearings; termination.

(a) Formal hearings are normally terminated upon the conclusion of the proceeding at which evidence is submitted to the administrative law judge.

(b) In exceptional cases the Chief Administrative Law Judge or the administrative law judge assigned to the case may, in his or her discretion, extend the time for official termination of the hearing.

[42 FR 42552, Aug. 23, 1977]

§ 702.348 Formal hearings; preparation of final decision and order; content.

Within 20 days after the official termination of the hearing as defined by § 702.347, the administrative law judge shall have prepared a final decision and order, in the form of a compensation order, with respect to the claim, making an award to the claimant or rejecting the claim. The compensation order shall contain appropriate findings of facts and conclusions of law with respect thereto, and shall be concluded with one or more paragraphs containing the order of the administrative law judge, his signature, and the date of issuance.

§ 702.349 Formal hearings; filing and mailing of compensation orders; waiver of service; disposition of transcripts.

(a) An administrative law judge must, within 20 days after the official termination of the hearing, deliver by mail, or otherwise, to the district director that administered the claim, the transcript of the hearing, other documents or pleadings filed with him with respect to the claim, and his signed compensation order. Upon receipt thereof, the district director, being the official custodian of all records with respect to claims he administers, must formally date and file the transcript, pleadings, and compensation order in his office. Such filing must be accomplished by the close of business on the next succeeding working day, and the district director must, on the same day as the filing was accomplished, serve a copy of the compensation order on the parties and on the representatives of the parties, if any. Service on the parties and their representatives must be made by certified mail unless a party has previously waived service by this method under paragraph (b) of this section.

(b) All parties and their representatives are entitled to be served with compensation orders via registered or certified mail. Parties and their representatives may waive this right and elect to be served with compensation orders electronically by filing the appropriate waiver form with the district director responsible for administering the claim. To waive service by registered or certified mail, employers, insurance carriers, and their representatives must file form LS–801 (Waiver of Service by Registered or Certified Mail for Employers and/or Insurance Carriers), and claimants and their representatives must file form LS–802 (Waiver of Service by Registered or Certified Mail for Claimants and/or Authorized Representatives). A signature on a waiver form represents a knowing and voluntary waiver of that party's or representative's right to receive compensation orders via registered or certified mail.

(1) Waiving parties and representatives must provide a valid electronic address on the waiver form.

(2) Parties and representatives must submit a separate waiver form for each case in which they intend to waive the right to certified or registered mail service.

(3) A representative may not sign a waiver form on a party's behalf.

(4) All compensation orders issued in a claim after receipt of the waiver form will be sent to the electronic address provided on the waiver form. Any changes to the address must be made by submitting another waiver form. Individuals may revoke their service waiver at any time by submitting a new waiver form that specifies that the service waiver is being revoked.

(5) If it appears that service in the manner selected by the individual has not been effective, the district director will serve the individual by certified mail.

[80 FR 12931, Mar. 12, 2015]

§ 702.350 Finality of compensation orders.

Compensation orders shall become effective when filed in the office of the district director, and unless proceedings for suspension or setting aside of such orders are instituted within 30 days of such filing, shall become final at the expiration of the 30th day after

such filing, as provided in section 21 of the Act 33 U.S.C. 921. If any compensation payable under the terms of such order is not paid within 10 days after it becomes due, section 14(f) of the Act requires that there be added to such unpaid compensation an amount equal to 20 percent thereof which shall be paid at the same time as, but in addition to, such compensation unless review of the compensation order is had as provided in such section 21 and an order staying payment has been issued by the Benefits Review Board or the reviewing court.

§ 702.351 Withdrawal of controversion of issues set for formal hearing; effect.

Whenever a party withdraws his controversion of the issues set for a formal hearing, the administrative law judge shall halt the proceedings upon receipt from said party of a signed statement to that effect and forthwith notify the district director who shall then proceed to dispose of the case as provided for in § 702.315.

INTERLOCUTORY MATTERS, SUPPLEMENTARY ORDERS, AND MODIFICATIONS

§ 702.371 Interlocutory matters.

Compensation orders shall not be made or filed with respect to interlocutory matters of a procedural nature arising during the pendency of a compensation case.

§ 702.372 Supplementary compensation orders.

(a) In any case in which the employer or insurance carrier is in default in the payment of compensation due under any award of compensation, for a period of 30 days after the compensation is due and payable, the person to whom such compensation is payable may, within 1 year after such default, apply in writing to the district director for a supplementary compensation order declaring the amount of the default. Upon receipt of such application, the district director will institute proceedings with respect to such application as if such application were an original claim for compensation, and the matter will be disposed of as provided for in § 702.315, or if agreement on the issue is not reached, then as in §§ 702.316 through 702.319.

(b) If, after disposition of the application as provided for in paragraph (a) of this section, a supplementary compensation order is entered declaring the amount of the default, which amount may be the whole of the award notwithstanding that only one or more installments is in default, a copy of such supplementary order must be filed and served in accordance with § 702.349. Thereafter, the applicant may obtain and file with the clerk of the Federal district court for the judicial district where the injury occurred or the district in which the employer has his principal place of business or maintains an office, a certified copy of said order and may seek enforcement thereof as provided for by section 18 of the Act, 33 U.S.C. 918.

[80 FR 12932, Mar. 12, 2015]

§ 702.373 Modification of awards.

(a) Upon his/her own initiative, or upon application of any party in interest (including an employer or carrier which has been granted relief under section 8(f) of the Act, 33 U.S.C. 908(f)), the district director may review any compensation case (including a case under which payments are made pursuant to section 44(i) of the Act, 33 U.S.C. 944(i)) in accordance with the procedure in subpart C of this part, and after such review of the case under § 702.315, or review at formal hearings under the regulations governing formal hearings in subpart C of this part, file a new compensation order terminating, continuing, reinstating, increasing or decreasing such compensation, or awarding compensation. Such new order shall not affect any compensation previously paid, except that an award increasing the compensation rate may be made retroactive from the date of injury, and if any part of the compensation due or to become due is unpaid, an award decreasing the compensation rate may be made effective from the date of the injury, and any payment made prior thereto in excess of such decreased rate shall be deducted from any unpaid compensation, in such manner and by such method as may be determined by the district director or the

administrative law judge. Settlements cannot be modified.

(b) Review of a compensation case under this section may be made at any time prior to 1 year after the date of the last payment of compensation, whether or not a compensation order has been issued, or at any time prior to 1 year after the rejection of a claim.

(c) Review of a compensation case may be had only for the reason that there is a change in conditions or that there was a mistake in the determination of facts.

(d) If the investigation, described in §702.148(c), discloses a change in conditions and the employer or insurance carrier intends to pursue modification of the award of compensation the district director and claimant shall be notified through an informal conference. At the conclusion of the informal conference the district director shall issue a recommendation either for or against the modification. This recommendation shall also be sent to the Associate Director, Division of Longshoremen's and Harbor Workers' Compensation (DLHWC) for a determination on whether or not to participate in the modification proceeding on behalf of the special fund. Lack of concurrence of the Associate Director, DLHWC or lack of participation by a representative of the special fund shall not be a bar to the modification proceeding.

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 401, Jan. 3, 1985]

APPEALS

§ 702.391 Appeals; where.

Appeals may be taken to the Benefits Review Board, U.S. Department of Labor, Washington, D.C. 20210, by filing a notice of appeals with the office of the district director for the compensation district in which the decision or order appealed from was filed and by submitting to the Board a petition for review of such decision or order, in accordance with the provisions of part 802 of this title 20.

§ 702.392 Appeals; what may be appealed.

An appeal raising a substantial question of law or fact may be taken from a decision with respect to a claim under the Act. Such appeals may be taken from compensation orders when they have been filed as provided for in §702.349.

§ 702.393 Appeals; time limitations.

The notice of appeal (see §702.391) shall be filed with the district director within 30 days of the filing of the decision or order complained of, as defined and described in §§802.205 and 802.206 of this title. A petition for review of the decision or order is required to be filed within 30 days after receipt of the Board's acknowledgment of the notice of appeal, as provided in §802.210 of this title.

§ 702.394 Appeals; procedure.

The procedure for appeals to the Benefits Review Board shall be as provided by the Board in its Rules of Practice and Procedure, set forth in part 802 of this title.

Subpart D—Medical Care and Supervision

§ 702.401 Medical care defined.

(a) Medical care shall include medical, surgical, and other attendance or treatment, nursing and hospital services, laboratory, X-ray and other technical services, medicines, crutches, or other apparatus and prosthetic devices, and any other medical service or supply, including the reasonable and necessary cost of travel incident thereto, which is recognized as appropriate by the medical profession for the care and treatment of the injury or disease.

(b) An employee may rely on treatment by prayer or spiritual means alone, in accordance with the tenets and practice of a recognized church or religious denomination, by an accredited practitioner of such recognized church or religious denomination, and nursing services rendered in accordance with such tenets and practice without loss or diminution of compensation or benefits under the Act. For purposes of this section, a recognized church or religious denomination shall be any religious organization: (1) That is recognized by the Social Security Administration for purposes of reimbursements for treatment under Medicare and Medicaid or (2) that is

recognized by the Internal Revenue Service for purposes of tax exempt status.

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 402, Jan. 3, 1985]

§ 702.402 Employer's duty to furnish; duration.

It is the duty of the employer to furnish appropriate medical care (as defined in § 702.401(a)) for the employee's injury, and for such period as the nature of the injury or the process of recovery may require.

[50 FR 402, Jan. 3, 1985]

§ 702.403 Employee's right to choose physician; limitations.

The employee shall have the right to choose his/her attending physician from among those authorized by the Director, OWCP, to furnish such care and treatment, except those physicians included on the Secretary's list of debarred physicians. In determining the choice of a physician, consideration must be given to availability, the employee's condition and the method and means of transportation. Generally 25 miles from the place of injury, or the employee's home is a reasonable distance to travel, but other pertinent factors must also be taken into consideration.

[50 FR 402, Jan. 3, 1985]

§ 702.404 Physician defined.

The term *physician* includes doctors of medicine (MD), surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law. The term includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation shown by X-ray or clinical findings. Physicians defined in this part may interpret their own X-rays. All physicians in these categories are authorized by the Director to render medical care under the Act. Naturopaths, faith healers, and other practitioners of the healing arts which are not listed herein are not included within the term ''physician'' as used in this part.

[42 FR 45303, Sept. 9, 1977]

§ 702.405 Selection of physician; emergencies.

Whenever the nature of the injury is such that immediate medical care is required and the injured employee is unable to select a physician, the employer shall select a physician. Thereafter the employee may change physicians when he is able to make a selection. Such changes shall be made upon obtaining written authorization from the employer or, if consent is withheld, from the district director. The Director will direct reimbursement of medical claims for services rendered by physicians or health care providers who are on the list of those excluded from providing care under the Act, if such services were rendered in an emergency. (See §§ 702.417 and 702.435(b)).

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 402, Jan. 3, 1985]

§ 702.406 Change of physicians; nonemergencies.

(a) Whenever the employee has made his initial, free choice of an attending physician, he may not thereafter change physicians without the prior written consent of the employer (or carrier) or the district director. Such consent shall be given in cases where an employee's initial choice was not of a specialist whose services are necessary for, and appropriate to, the proper care and treatment of the compensable injury or disease. In all other cases, consent may be given upon a showing of good cause for change.

(b) The district director for the appropriate compensation district may order a change of physicians or hospitals when such a change is found to be necessary or desirable or where the fees charged exceed those prevailing within the community for the same or similar services or exceed the provider's customary charges.

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 402, Jan. 3, 1985]

§ 702.407 Supervision of medical care.

The Director, OWCP, through the district directors and their designees,

shall actively supervise the medical care of an injured employee covered by the Act. Such supervision shall include:

(a) The requirement that periodic reports on the medical care being rendered be filed in the office of the district director, the frequency thereof being determined by order of the district director or sound judgment of the attending physician as the nature of the injury may dictate;

(b) The determination of the necessity, character and sufficiency of any medical care furnished or to be furnished the employee, including whether the charges made by any medical care provider exceed those permitted under the Act;

(c) The determination of whether a change of physicians, hospitals or other persons or locales providing treatment should be made or is necessary;

(d) The further evaluation of medical questions arising in any case under the Act, with respect to the nature and extent of the covered injury, and the medical care required therefor.

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 402, Jan. 3, 1985]

§ 702.408 Evaluation of medical questions; impartial specialists.

In any case in which medical questions arise with respect to the appropriate diagnosis, extent, effect of, appropriate treatment, and the duration of any such care or treatment, for an injury covered by the Act, the Director, OWCP, through the district directors having jurisdiction, shall have the power to evaluate such questions by appointing one or more especially qualified physicians to examine the employee, or in the case of death to make such inquiry as may be appropriate to the facts and circumstances of the case. The physician or physicians, including appropriate consultants, should report their findings with respect to the questions raised as expeditiously as possible. Upon receipt of such report, action appropriate therewith shall be taken.

§ 702.409 Evaluation of medical questions; results disputed.

Any party who is dissatisfied with such report may request a review or reexamination of the employee by one or more different physicians employed by or selected by the Director, and such review or reexamination shall be granted unless it is found that it is clearly unwarranted. Such review shall be completed within 2 weeks from the date ordered unless it is impossible to complete the review and render a report thereon within such time period. Upon receipt of the report of this additional review and reexamination, such action as may be appropriate shall forthwith be taken.

§ 702.410 Duties of employees with respect to special examinations.

(a) For any special examination required of an employee by §§ 702.408 and 702.409, the employee shall submit to such examination at such place as is designated in the order to report, but the place so selected shall be reasonably convenient for the employee.

(b) Where an employee fails to submit to an examination required by §§ 702.408 and 702.409, the district director or administrative law judge may order that no compensation otherwise payable shall be paid for any period during which the employee refuses to submit to such examination unless circumstances justified the refusal.

(c) Where an employee unreasonably refuses to submit to medical or surgical treatment, or to an examination by a physician selected by the employer, the district director or administrative law judge may by order suspend the payment of further compensation during such time as the refusal continues. Except that refusal to submit to medical treatment because of adherence to the tenets of a recognized church or religious denomination as described in § 702.401(b) shall not cause the suspension of compensation.

[42 FR 45303, Sept. 9, 1977, as amended at 50 FR 402, Jan. 3, 1985; 51 FR 4286, Feb. 3, 1986]

§ 702.411 Special examinations; nature of impartiality of specialists.

(a) The special examinations required by § 702.408 shall be accomplished in a

manner designed to preclude prejudgment by the impartial examiner. No physician previously connected with the case shall be present, nor may any other physician selected by the employer, carrier, or employee be present. The impartial examiner may be made aware, by any party or by the OWCP, of the opinions, reports, or conclusions of any prior examining physician with respect to the nature and extent of the impairment, its cause, or its effect upon the wage-earning capacity of the injured employee, if the district director determines that, for good cause, such opinions, reports, or conclusions shall be made available. Upon request, any party shall be given a copy of all materials made available to the impartial examiner.

(b) The impartiality of the specialists shall not be considered to have been compromised if the district director deems it advisable to, and does, apprise the specialist by memorandum of those undisputed facts pertaining to the nature of the employee's employment, of the nature of the injury, of the post-injury employment activity, if any, and of any other facts which are not disputed and are deemed pertinent to the type of injury and/or the type of examination being conducted.

(c) No physician selected to perform impartial examinations shall be, or shall have been for a period of 2 years prior to the examination, an employee of an insurance carrier or self-insured employer, or who has accepted or participated in any fee from an insurance carrier or self-insured employer, unless the parties in interest agree thereto.

[38 FR 26861, Sept. 26, 1973, as amended at 42 FR 45303, Sept. 9, 1977]

§ 702.412 Special examinations; costs chargeable to employer or carrier.

(a) The Director or his designee ordering the special examination shall have the power, in the exercise of his discretion, to charge the cost of the examination or review to the employer, to the insurance carrier, or to the special fund established by section 44 of the Act, 33 U.S.C. 944.

(b) The Director or his designee may also order the employer or the insurance carrier to provide the employee with the services of an attendant, where the district director considers such services necessary, because the employee is totally blind, has lost the use of both hands, or both feet or is paralyzed and unable to walk, or because of other disability making the employee so helpless as to require constant attendance in the discretion of the district director. Fees payable for such services shall be in accord with the provisions of § 702.413.

[42 FR 45303, Sept. 9, 1977]

§ 702.413 Fees for medical services; prevailing community charges.

All fees charged by medical care providers for persons covered by this Act shall be limited to such charges for the same or similar care (including supplies) as prevails in the community in which the medical care provider is located and shall not exceed the customary charges of the medical care provider for the same or similar services. Where a dispute arises concerning the amount of a medical bill, the Director shall determine the prevailing community rate using the OWCP Medical Fee Schedule (as described in 20 CFR 10.805 *through 10.810*) to the extent appropriate, and where not appropriate, may use other state or federal fee schedules. The opinion of the Director that a charge by a medical care provider disputed under the provisions of section 702.414 exceeds the charge which prevails in the community in which said medical care provider is located shall constitute sufficient evidence to warrant further proceedings pursuant to section 702.414 and to permit the Director to direct the claimant to select another medical provider for care to the claimant.

[60 FR 51348, Oct. 2, 1995, as amended at 77 FR 37286, June 21, 2012]

§ 702.414 Fees for medical services; unresolved disputes on prevailing charges.

(a) The Director may, upon written complaint of an interested party, or upon the Director's own initiative, investigate any medical care provider or any fee for medical treatment, services, or supplies that appears to exceed prevailing community charges for similar treatment, services or supplies or the provider's customary charges.

The OWCP medical fee schedule (see section 702.413) shall be used by the Director, where appropriate, to determine the prevailing community charges for a medical procedure by a physician or hospital (to the extent such procedure is covered by the OWCP fee schedule). The Director's investigation may initially be conducted informally through contact of the medical care provider by the district director. If this informal investigation is unsuccessful further proceedings may be undertaken. These proceedings may include, but not be limited to: an informal conference involving all interested parties; agency interrogatories to the pertinent medical care provider; and issuance of subpoenas duces tecum for documents having a bearing on the dispute.

(1) A claim by the provider that the OWCP fee schedule does not represent the prevailing community rate will be considered only where the following circumstances are presented:

(i) where the actual procedure performed was incorrectly identified by medical procedure code;

(ii) that the presence of a severe or concomitant medical condition made treatment especially difficult;

(iii) the provider possessed unusual qualifications (board certification in a specialty is not sufficient evidence in itself of unusual qualifications); or

(iv) the provider or service is not one covered by the OWCP fee schedule as described by 20 CFR 10.805 *through 10.810*.

(2) The circumstances listed in paragraph (a)(1) of this section are the only ones which will justify reevaluation of the amount calculated under the OWCP fee schedule.

(b) The failure of any medical care provider to present any evidence required by the Director pursuant to this section without good cause shall not prevent the Director from making findings of fact.

(c) After any proceeding under this section the Director shall make specific findings on whether the fee exceeded the prevailing community charges (as established by the OWCP fee schedule, where appropriate) or the provider's customary charges and provide notice of these findings to the affected parties.

(d) The Director may suspend any such proceedings if after receipt of the written complaint the affected parties agree to withdraw the controversy from agency consideration on the basis that such controversy has been resolved by the affected parties. Such suspension, however, shall be at the discretion of the Director.

[51 FR 4286, Feb. 3, 1986, as amended at 60 FR 51348, Oct. 2, 1995; 77 FR 37286, June 21, 2012]

§ 702.415 Fees for medical services; unresolved disputes on charges; procedure.

After issuance of specific findings of fact and proposed action by the Director as provided in § 702.414 any affected provider employer or other interested party has the right to seek a hearing pursuant to section 556 of title 5, United States Code. Upon written request for such a hearing, the matter shall be referred by the District Director to the OALJ for formal hearing in accordance with the procedures in subpart C of this part. If no such request for a hearing is filed with the district director within thirty (30) days the findings issued pursuant to § 702.414 shall be final.

[51 FR 4286, Feb. 3, 1986]

§ 702.416 Fees for medical services; disputes; hearings; necessary parties.

At formal hearings held pursuant to § 702.415, the necessary parties shall be the person whose fee or cost charge is in question and the Director, or their representatives. The employer or carrier may also be represented, and other parties, or associations having an interest in the proceedings, may be heard, in the discretion of the administrative law judge.

§ 702.417 Fees for medical services; disputes; effect of adverse decision.

If the final decision and order upholds the finding of the Director that the fee or charge in dispute was not in accordance with prevailing community charges or the provider's customary charges, the person claiming such fee or cost charge shall be given thirty (30) days after filing of such decision and order to make the necessary adjustment. If such person still refuses to

make the required readjustment, such person shall not be authorized to conduct any further treatments or examinations (if a physician) or to provide any other services or supplies (if by other than a physician). Any fee or cost charge subsequently incurred for services performed or supplies furnished shall not be a reimbursable medical expense under this subpart. This prohibition shall apply notwithstanding the fact that the services performed or supplies furnished were in all other respects necessary and appropriate within the provision of these regulations. However, the Director may direct reimbursement of medical claims for services rendered if such services were rendered in an emergency (see § 702.435(b)). At the termination of the proceedings provided for in this section the district director shall determine whether further proceedings under § 702.432 should be initiated.

[50 FR 403, Jan. 3, 1985]

MEDICAL PROCEDURES

§ 702.418 Procedure for requesting medical care; employee's duty to notify employer.

(a) As soon as practicable, but within 30 days after occurrence of an injury covered by the Act, or within 30 days after an employee becomes aware, or in the exercise of reasonable diligence should be aware, of the relationship between an injury or disease and his employment, the injured employee or someone on his behalf shall give written notice thereof to the district director having jurisdiction over the place where the injury occurred and to the employer. If a form has been prescribed for such purpose it shall be used, if available and practicable under the circumstances. Notices filed under subpart B of this part, if on the form prescribed by the Director for such purpose, satisfy the written notice requirements of this subpart.

(b) In the case of an occupational disease which does not immediately result in a disability or death, such notice shall be given within one year after the employee becomes aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship between the employment, the disease, and the death or disability. Notice shall be given: (1) To the district director in the compensation district in which the injury or death occurred, and (2) to the employer.

(Approved by the Office of Management and Budget under control number 1215–0160)

[50 FR 403, Jan. 3, 1985]

§ 702.419 Action by employer upon acquiring knowledge or being given notice of injury.

Whenever an employer acquires knowledge of an employee's injury, through receipt of a written notice or otherwise, said employer shall forthwith authorize, in writing, appropriate medical care. If a form is prescribed for this purpose it shall be used whenever practicable. Authorization shall also be given in cases where an employee's initial choice was not of a specialist whose services are necessary for and appropriate to the proper care and treatment of the compensable injury or disease. In all other cases, consent may be given upon a showing of good cause for change.

[50 FR 403, Jan. 3, 1985]

§ 702.420 Issuance of authorization; binding effect upon insurance carrier.

The issuance of an authorization for treatment by the employer shall bind his insurance carrier to furnish and pay for such care and services.

§ 702.421 Effect of failure to obtain initial authorization.

An employee shall not be entitled to recover for medical services and supplies unless:

(a) The employer shall have refused or neglected a request to furnish such services and the employee has complied with sections 7 (b) and (c) of the Act, 33 U.S.C. 907 (b) and (c) and these regulations; or

(b) The nature of the injury required such treatment and services and the employer or his superintendent or foreman having knowledge of such injury shall have neglected to provide or authorize same.

[50 FR 403, Jan. 3, 1985]

§ 702.422 Effect of failure to report on medical care after initial authorization.

(a) Notwithstanding that medical care is properly obtained in accordance with these regulations, a finding by the Director that a medical care provider has failed to comply with the reporting requirements of the Act shall operate as a mandatory revocation of authorization of such medical care provider. The effect of a final finding to this effect operates to release the employer/carrier from liability of the expenses of such care. In addition to this, when such a finding is made by the Director, the claimant receiving treatment will be directed by the district director to seek authorization for medical care from another source.

(b) For good cause shown, the Director may excuse the failure to comply with the reporting requirements of the Act and further, may make an award for the reasonable value of such medical care.

[50 FR 403, Jan. 3, 1985]

DEBARMENT OF PHYSICIANS AND OTHER PROVIDERS OF MEDICAL SERVICES AND SUPPLIERS AND CLAIMS REPRESENTATIVES

§ 702.431 Grounds for debarment.

A physician or health care provider shall be debarred if it is found, after appropriate investigation as described in § 702.414 and proceedings under §§ 702.432 and 702.433, that such physician or health care provider has:

(a) Knowingly and willfully made, or caused to be made, any false statement or misrepresentation of a material fact for use in a claim for compensation or claim for reimbursement of medical expenses under this Act;

(b) Knowingly and willfully submitted, or caused to be submitted, a bill or request for payment under this Act containing a charge which the Director finds to be substantially in excess of the charge for the service, appliance, or supply prevailing within the community or in excess of the provider's customary charges, unless the Director finds there is good cause for the bill or request containing the charge;

(c) Knowingly and willfully furnished a service, appliance, or supply which is determined by the Director to be substantially in excess of the need of the recipient thereof or to be of a quality which substantially fails to meet professionally recognized standards;

(d) Been convicted under any criminal statute, without regard to pending appeal thereof, for fraudulent activities in connection with federal or state program for which payments are made to physicians or providers of similar services, appliances, or supplies; or has otherwise been excluded from participation in such program.

(e) The fact that a physician or health care provider has been convicted of a crime previously described in (d), or excluded or suspended, or has resigned in lieu of exclusion or suspension, from participation in any program as described in (d), shall be a prima facie finding of fact for purposes of section 7(j)(2) of the Act, 33 U.S.C. 907(j)(2).

[50 FR 404, Jan. 3, 1985]

§ 702.432 Debarment process.

(a) *Pertaining to health care providers.* Upon receipt of information indicating that a physician or health care provider has engaged in activities enumerated in subparagraphs (a) through (c) of § 702.431, the Director, through the Director's designees, may evaluate the information (as described in § 702.414) to ascertain whether proceedings should be initiated against the physician or health care provider to remove authorization to render medical care or service under the Longshore and Harbor Workers' Compensation Act.

(b) *Pertaining to health care providers and claims representatives.* If after appropriate investigation the Director determines that proceedings should be initiated, written notice thereof must be provided to the physician, health care provider or claims representative. Notice must contain the following:

(1) A concise statement of the grounds upon which debarment will be based;

(2) A summary of the information upon which the director has relied in reaching an initial decision that debarment proceedings should be initiated;

(3) An invitation to the physician, health care provider or claims representative to: (i) Resign voluntarily from participation in the program without admitting or denying the allegations presented in the written notice; or (ii) request a decision on debarment to be based upon the existing agency record and any other information the physician, health care provider or claims representative may wish to provide;

(4) A notice of the physician's, health care provider's or claims representative's right, in the event of an adverse ruling by the Director, to request a formal hearing before an administrative law judge;

(5) A notice that should the physician, health care provider or claims representative fail to provide written answer to the written notice described in this section within thirty (30) days of receipt, the Director may deem the allegations made therein to be true and may order exclusion of the physician, health care provider or claims representative without conducting any further proceedings; and

(6) The name and address of the district director who will be responsible for receiving the answer from the physician, health care provider or claims representative.

(c) Should the physician, health care provider or claims representative fail to file a written answer to the notice described in this section within thirty (30) days of receipt thereof, the Director may deem the allegations made therein to be true and may order debarment of the physician, health care provider or claims representative.

(d) The physician, health care provider or claims representative may inspect or request copies of information in the agency records at any time prior to the Director's decision.

(e) The Director must issue a decision in writing, and must send a copy of the decision to the physician, health care provider or claims representative. The decision must advise the physician, health care provider or claims representative of the right to request, within thirty (30) days of the date of an adverse decision, a formal hearing before an administrative law judge under the procedures set forth herein. The filing of such a request for hearing within the time specified will operate to stay the effectiveness of the decision to debar.

[50 FR 404, Jan. 3, 1985, as amended at 80 FR 12932, Mar. 12, 2015]

§ 702.433 Requests for hearing.

(a) A request for hearing must be sent to the district director and contain a concise notice of the issues on which the physician, health care provider or claims representative desires to give evidence at the hearing with identification of witnesses and documents to be submitted at the hearing.

(b) If a request for hearing is timely received by the district director, the matter must be referred to the Chief Administrative Law Judge who must assign it for hearing with the assigned administrative law judge issuing a notice of hearing for the conduct of the hearing. A copy of the hearing notice must be served on the physician, health care provider or claims representative.

(c) If a request for hearing contains identification of witnesses or documents not previously considered by the Director, the Director may make application to the assigned administrative law judge for an offer of proof from the physician, health care provider or claims representative for the purpose of discovery prior to hearing. If the offer of proof indicates injection of new issues or new material evidence not previously considered by the Director, the Director may request a remand order for purposes of reconsideration of the decision made pursuant to § 702.432 of these regulations.

(d) The parties may make application for the issuance of subpoenas upon a showing of good cause therefore to the administrative law judge.

(e) The administrative law judge will issue a recommended decision after the termination of the hearing. The recommended decision must contain appropriate findings, conclusions, and a recommended order and be forwarded, together with the record of the hearing, to the Administrative Review Board for a decision. The recommended decision must be served upon all parties to the proceeding.

(f) Based upon a review of the record and the recommended decision of the administrative law judge, the Administrative Review Board will issue a decision.

[50 FR 404, Jan. 3, 1985, as amended at 55 FR 28606, July 12, 1990; 61 FR 19984, May 3, 1996; 80 FR 12932, Mar. 12, 2015; 85 FR 13030, Mar. 6, 2020; 85 FR 30616, May 20, 2020]

§ 702.434 Judicial review.

(a) Any physician, health care provider, or claims representative who participated as a party in the hearing may obtain review of the Department's final decision made by the Administrative Review Board or the Secretary, as appropriate, regardless of the amount of controversy, by commencing a civil action within sixty (60) days after the decision is transmitted to him or her. The pendency of such review will not stay the effect of the decision. Such action must be brought in the Court of Appeals of the United States for the judicial circuit in which the plaintiff resides or has his or her principal place of business, or the Court of Appeals for the District of Columbia pursuant to section 7(j)(4) of the Act, 33 U.S.C. 907(j)(4).

(b) As part of the Department's answer, the Administrative Review Board must file a certified copy of the transcript of the record of the hearing, including all evidence submitted in connection therewith.

(c) The findings of fact contained in the Department's final decision, if based on substantial evidence in the record as a whole, shall be conclusive.

[85 FR 30616, May 20, 2020]

§ 702.435 Effects of debarment.

(a) The Director shall give notice of the debarment of a physician, hospital, or provider of medical support services or supplies to:

(1) All OWCP district offices;

(2) The Health Care Financing Administration;

(3) The State or Local authority responsible for licensing or certifying the debarred party;

(4) The employers and authorized insurers under the Act by means of an annual bulletin sent to them by the Director; and

(5) The general public by posting in the district office in the jurisdiction where the debarred party maintains a place of business.

If a claims representative is debarred, the Director shall give notice to those groups listed in paragraphs (a) (1), (3), (4), and (5) of this section.

(b) Notwithstanding any debarment under this subpart, the Director shall not refuse a claimant reimbursement for any otherwise reimbursable medical expense if the treatment, service or supply was rendered by debarred provider in an emergency situation. However, such claimant will be directed by the Director to select a duly qualified provider upon the earliest opportunity.

[50 FR 405, Jan. 3, 1985]

§ 702.436 Reinstatement.

(a) If a physician or health care provider has been debarred or pursuant to § 702.431(d) or if a claims representative has been debarred pursuant to § 702.131(c) (1) or (3) the person debarred will be automatically reinstated upon notice to the Director that the conviction or exclusion has been reversed or withdrawn. However, such reinstatement will not preclude the Director from instituting debarment proceedings based upon the subject matter involved.

(b) A physician, health care provider or claims representative otherwise debarred by the Director may apply for reinstatement to participate in the program by application to the Director after three years from the date of entry of the order of exclusion. Such application for reinstatement shall be addressed to the Associate Director for the Longshore program, and shall contain a statement of the basis of the application along with any supporting documentation.

(c) The Director may further investigate the merits of the reinstatement application by requiring special reporting procedures from the applicant for a probationary period not to exceed six months to be monitored by the district office where the provider maintains a place of business.

(d) At the end of aforesaid probationary period, the Director may order

full reinstatement of the physician, health care provider or claims representative if such reinstatement is clearly consistent with the program goal to protect itself against fraud and abuse and, further, if the physician, health care provider or claims representative has given reasonable assurances that the basis for the debarment will not be repeated.

[50 FR 405, Jan. 3, 1985]

HEARING LOSS CLAIMS

§ 702.441 Claims for loss of hearing.

(a) Claims for hearing loss pending on or filed after September 28, 1984 (the date of enactment of Pub. L. 98–426) shall be adjudicated with respect to the determination of the degree of hearing impairment in accordance with these regulations.

(b) An audiogram shall be presumptive evidence of the amount of hearing loss on the date administered if the following requirements are met:

(1) The audiogram was administered by a licensed or certified audiologist, by a physician certified by the American Board of Otolaryngology, or by a technician, under an audiologist's or physician's supervision, certified by the Council of Accreditation on Occupational Hearing Conservation, or by any other person considered qualified by a hearing conservation program authorized pursuant to 29 CFR 1910.95(g)(3) promulgated under the Occupational Safety and Health Act of 1970 (29 U.S.C. 667). Thus, either a professional or trained technician may conduct audiometric testing. However, to be acceptable under this subsection, a licensed or certified audiologist or otolaryngologist, as defined, must ultimately interpret and certify the results of the audiogram. The accompanying report must set forth the testing standards used and describe the method of evaluating the hearing loss as well as providing an evaluation of the reliability of the test results.

(2) The employee was provided the audiogram and a report thereon at the time it was administered or within thirty (30) days thereafter.

(3) No one produces a contrary audiogram of equal probative value (meaning one performed using the standards described herein) made at the same time. ''Same time'' means within thirty (30) days thereof where noise exposure continues or within six (6) months where exposure to excessive noise levels does not continue. Audiometric tests performed prior to the enactment of Public Law 98–426 will be considered presumptively valid if the employer complied with the procedures in this section for administering audiograms.

(c) In determining the amount of preemployment hearing loss, an audiogram must be submitted which was performed prior to employment or within thirty (30) days of the date of the first employment-related noise exposure. Audiograms performed after December 27, 1984 must comply with the standards described in paragraph (d) of this section.

(d) In determining the loss of hearing under the Act, the evaluators shall use the criteria for measuring and calculating hearing impairment as published and modified from time-to-time by the American Medical Association in the *Guides to the Evaluation of Permanent Impairment*, using the most currently revised edition of this publication. In addition, the audiometer used for testing the individual's threshold of hearing must be calibrated according to current American National Standard Specifications for Audiometers. Audiometer testing procedures required by hearing conservation programs pursuant to the Occupational Safety and Health Act of 1970 should be followed (as described at 29 CFR 1910.95 and appendices).

(Approved by the Office of Management and Budget under control number 1215–0160)

[50 FR 405, Jan. 3, 1985]

Subpart E—Vocational Rehabilitation

§ 702.501 Vocational rehabilitation; objective.

The objective of vocational rehabilitation is the return of permanently disabled persons to gainful employment commensurate with their physical or mental impairments, or both, through a program of reevaluation or redirection of their abilities, or retraining in

another occupation, or selective job placement assistance.

§ 702.502 Vocational rehabilitation; action by district directors.

All injury cases which are likely to result in, or have resulted in, permanent disability, and which are of a character likely to require review by a vocational rehabilitation adviser on the staff of the Director, shall promptly be referred to such adviser by the district director or his designee having charge of the case. A form has been prescribed for such purpose and shall be used. Medical data and other pertinent information shall accompany the referral.

(Approved by the Office of Management and Budget under control number 1215–0051)

(Pub. L. No. 96–511)

[38 FR 26861, Sept. 26, 1973, as amended at 49 FR 18294, Apr. 30, 1984]

§ 702.503 Vocational rehabilitation; action by adviser.

The vocational rehabilitation adviser, upon receipt of the referral, shall promptly consider the feasibility of a vocational referral or request for cooperative services from available resources or facilities, to include counseling, vocational survey, selective job placement assistance, and retraining. Public or private agencies may be utilized in arranging necessary vocational rehabilitation services under the Federal Vocational Rehabilitation Act, 29 U.S.C. 31 *et seq.*

§ 702.504 Vocational rehabilitation; referrals to State Employment Agencies.

Vocational rehabilitation advisers will arrange referral procedures with State Employment Service units within their assigned geographical districts for the purpose of securing employment counseling, job classification, and selective placement assistance. Referrals shall be made to State Employment Offices based upon the following:

(a) Vocational rehabilitation advisers will screen cases so as to refer only those disabled employees who are considered to have employment potential;

(b) Only employees will be referred who have permanent, compensable disabilities resulting in a significant vocational handicap and loss of wage earning capacity;

(c) Disabled employees, whose initial referral to former private employers did not result in a job reassignment or in a job retention, shall be referred for employment counseling and/or selective placement unless retraining services consideration is requested;

(d) The vocational rehabilitation advisers shall arrange for employees' referrals if it is ascertained that they may benefit from registering with the State Employment Service;

(e) Referrals will be made to appropriate State Employment Offices by letter, including all necessary information and a request for a report on the services provided the employee when he registers;

(f) The injured employee shall be advised of available job counseling services and informed that he is being referred for employment and selective placement;

(g) A followup shall be made within 60 days on all referrals to assure uniform reporting by State agencies on cases referred for a vocational survey.

§ 702.505 Vocational rehabilitation; referrals to other public and private agencies.

Referrals to such other public and private agencies providing assistance to disabled persons such as public welfare agencies, Public Health Services facilities, social services units of the Veterans Administration, the Social Security Administration, and other such agencies, shall be made by the vocational rehabilitation adviser, where appropriate, on an individual basis when requested by disabled employees. Such referrals do not provide for a service cost reimbursement by the Department of Labor.

§ 702.506 Vocational rehabilitation; training.

Vocational rehabilitation training shall be planned in anticipation of a short, realistic, attainable vocational objective terminating in remunerable employment, and in restoring wage-earning capacity or increasing it materially. The following procedures shall

apply in arranging for or providing training:

(a) The vocational rehabilitation adviser shall arrange for and develop all vocational training programs.

(b) Training programs shall be developed to meet the varying needs of eligible beneficiaries, and may include courses at colleges, technical schools, training at rehabilitation centers, on-the-job training, or tutorial courses. The courses shall be pertinent to the occupation for which the employee is being trained.

(c) Training may be terminated if the injured employee fails to cooperate with the Department of Labor or with the agency supervising his course of training. The employee shall be counseled before training is terminated.

(d) Reports shall be required at periodic intervals on all persons in approved training programs.

§ 702.507 Vocational rehabilitation; maintenance allowance.

(a) An injured employee who, as a result of injury, is or may be expected to be totally or partially incapacitated for a remunerative occupation and who, under the direction of the Director is being rendered fit to engage in a remunerative occupation, shall be paid additional compensation necessary for this maintenance, not exceeding $25 a week. The expense shall be paid out of the special fund established in section 44 of the Act, 33 U.S.C. 944. The maximum maintenance allowance shall not be provided on an automatic basis, but shall be based on the recommendation of a State agency that a claimant is unable to meet additional costs by reason of being in training.

(b) When required by reason of personal illness or hardship, limited periods of absence from training may be allowed without terminating the maintenance allowance. A maintenance allowance shall be terminated when it is shown to the satisfaction of the Director that a trainee is not complying reasonably with the terms of the training plan or is absenting himself without good cause from training so as to materially interfere with the accomplishment of the training objective.

§ 702.508 Vocational rehabilitation; confidentiality of information.

The following safeguards will be observed to protect the confidential character of information released regarding an individual undergoing rehabilitation:

(a) Information will be released to other agencies from which an injured employee has requested services only if such agencies have established regulations assuring that such information will be considered confidential and will be used only for the purpose for which it is provided;

(b) Interested persons and agencies have been advised that any information concerning rehabilitation program employees is to be held confidential;

(c) A rehabilitation employee's written consent is secured for release of information regarding disability to a person, agency, or establishment seeking the information for purposes other than the approved rehabilitation planning with such employee.

Subpart F—Occupational Disease Which Does Not Immediately Result in Death or Disability

SOURCE: 50 FR 406, Jan. 3, 1985, unless otherwise noted.

§ 702.601 Definitions.

(a) *Time of injury.* For purposes of this subpart and with respect to an occupational disease which does not immediately result in death or disability, the time of injury shall be deemed to be the date on which the employee or claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship between the employment, the disease, and the death or disability.

(b) *Disability.* With regard to an occupational disease for which the time of injury, as defined in § 702.601(a), occurs after the employee was retired, disability shall mean permanent impairment as determined according to the *Guides to the Evaluation of Permanent Impairment* which is prepared and modified from time-to-time by the American Medical Association, using the most currently revised edition of this

publication. If this guide does not evaluate the impairment, other professionally recognized standards may be utilized. The disability described in this paragraph shall be limited to permanent partial disability. For that reason they are not subject to adjustments under section 10(f) of the Act, 33 U.S.C. 910(f).

(c) *Retirement.* For purposes of this subpart, retirement shall mean that the claimant, or decedent in cases involving survivor's benefits, has voluntarily withdrawn from the workforce and that there is no realistic expectation that such person will return to the workforce.

[50 FR 406, Jan. 3, 1985, as amended at 51 FR 4286, Feb. 3, 1986]

§ 702.602 Notice and claims.

(a) *Time for giving notice of injury or death.* Refer to § 702.207.

(b) *Time for filing of claims.* Refer to § 702.212.

§ 702.603 Determining the payrate for compensating occupational disease claims which become manifest after retirement.

(a) If the time of injury occurs within the first year after the employee has retired, the payrate for compensation purposes shall be one fifty-second part of the employee's average annual earnings during the fifty-two week period preceding retirement.

(b) If the time of injury occurs more than one year after the employee has retired the payrate for compensation purposes shall be the national average weekly wage, determined according to section 6(b)(3) of the Act, 33 U.S.C. 906(b)(3), at the time of injury.

§ 702.604 Determining the amount of compensation for occupational disease claims which become manifest after retirement.

(a) If the claim is for disability benefits and the time of injury occurs after the employee has retired, compensation shall be 66⅔ percent of the payrate, as determined under § 702.603, times the disability, as determined according to § 702.601(b).

(b) If the claim is for death benefits and the time of injury occurs after the decedent has retired, compensation shall be the percent specified in section 9 of the Act, 33 U.S.C. 909, times the payrate determined according to § 702.603. Total weekly death benefits shall not exceed one fifty-second part of the decedent's average annual earnings during the fifty-two week period preceding retirement, such benefits shall be subject to the limitation provided for in section 6(b)(1) of the Act, 33 U.S.C. 906(b)(1).

[50 FR 406, Jan. 3, 1985, as amended at 51 FR 4286, Feb. 3, 1986]

Subpart G—Section 10(f) Adjustments

SOURCE: 83 FR 17290, Apr. 19, 2018, unless otherwise noted.

§ 702.701 What is an annual section 10(f) adjustment and how is it calculated?

(a) Claimants receiving compensation for permanent total disability or death benefits are entitled to section 10(f) adjustments each fiscal year. A section 10(f) adjustment cannot decrease the compensation or death benefits payable to any claimant.

(b) The section 10(f) adjustment for a given fiscal year is the lower of:

(1) The percentage by which the new fiscal year's national average weekly wage exceeds the prior fiscal year's national average weekly wage as determined by the Department (*see* § 702.804(b)); or

(2) 5 percent.

(c) Section 10(f) percentage increases are applied each October 1 to the amount of compensation or death benefits payable in the prior fiscal year.

(d) In applying section 10(f) adjustments—

(1) Calculations are rounded to the nearest dollar; and

(2) No adjustment is made if the calculated amount is less than one dollar.

(e) A section 10(f) adjustment must not increase a claimant's weekly compensation or death benefits beyond the applicable fiscal year's maximum rate.

(f) Section 10(f) adjustments do not apply to compensation for temporary or partial disability.

Subpart H—Maximum and Minimum Compensation Rates

SOURCE: 83 FR 17290, Apr. 19, 2018 unless otherwise noted.

GENERAL

§ 702.801 Scope and intent of this subpart.

(a) This subpart implements the Act's provisions that affect the maximum and minimum rates of compensation and death benefits payable to employees and survivors. These statutory provisions include sections 6(b) and (c), and 9(e). 33 U.S.C. 906(b), (c); 909(e). It is intended that these statutory provisions be construed as provided in this subpart.

(b) These regulations implement section 6(c), 33 U.S.C. 906(c), based on the following concepts:

(1) An employee is ''newly awarded compensation'' when he or she first becomes disabled due to an injury;

(2) A survivor is ''newly awarded compensation'' on the date the employee died; and

(3) An employee or survivor is ''currently receiving compensation'' when compensation for permanent total disability or death benefits is payable, regardless of when payment is actually made.

§ 702.802 Applicability of this subpart.

(a) This subpart applies to all compensation and death benefits paid under the Act as a result of injuries or deaths occurring on or after May 21, 2018 with the following exceptions:

(1) Amounts payable under an approved settlement (*see* 33 U.S.C. 908(i));

(2) Amounts paid for an employee's death to the Special Fund (*see* 33 U.S.C. 944(c)(1));

(3) Any payments for medical expenses (*see* 33 U.S.C. 907); and

(4) Any other lump sum payment of compensation or death benefits, including aggregate death benefits paid when a survivor remarries (*see* 33 U.S.C. 909(b)) or aggregate compensation paid under a commutation (*see* 33 U.S.C. 909(g)).

(b) The rules in this subpart governing minimum disability compensation and death benefits do not apply to claims arising under the Defense Base Act, 42 U.S.C. 1651 (*see* 42 U.S.C. 1652(a); 20 CFR 704.103).

§ 702.803 Definitions.

The following definitions apply to this subpart:

Calculated compensation rate means the amount of weekly compensation for total disability or death that a claimant would be entitled to if there were no maximum rates, minimum rates, or section 10(f) adjustments.

Date of disability. (1) Except as provided in paragraph (2) of this definition, the date of disability is the date on which the employee first became incapable, because of an injury, of earning the same wages the employee was receiving at the time of the injury.

(2) Exceptions:

(i) For scheduled permanent partial disability benefits under 33 U.S.C. 908(c)(1)–(20) that are not preceded by a permanent total, temporary total, or temporary partial disability resulting from the same injury, the date of disability is the date on which the employee first becomes permanently impaired by the injury to the scheduled member.

(ii) For an occupational disease that does not immediately result in disability, the date of disability is the date on which the employee becomes aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship between his or her employment, the disease, and the disability.

(iii) For any disability lasting 14 or fewer days, the date of disability is 4 days after the date on which the employee first became incapable, because of an injury, of earning the same wages the employee was receiving at the time of the injury.

Fiscal year or *FY* means the period from October 1 of a calendar year until September 30 of the following calendar year.

Maximum rate means the maximum weekly compensation rate calculated by the Department for a given fiscal year as described in § 702.804(b).

Minimum rate means the minimum weekly compensation rate calculated by the Department for a given fiscal year as described in § 702.804(c).

Section 10(f) adjustment means the annual increase that certain claimants receiving compensation for permanent total disability or death are entitled to each fiscal year under 33 U.S.C. 910(f) and as calculated by the Department as described in § 702.701(b).

§ 702.804 What are the weekly maximum and minimum rates for each fiscal year and how are they calculated?

(a) For each fiscal year, the Department must determine a weekly maximum and minimum compensation rate. These amounts are called the maximum and minimum rates in this subchapter. In combination with other factors, these rates are used to determine compensation payments under the Act.

(b) The maximum compensation rate in effect for a given fiscal year is 200% of the national average weekly earnings of production or nonsupervisory workers on private, nonagricultural payrolls, as calculated by the Department, for the first three quarters of the preceding fiscal year.

(c) The minimum compensation rate in effect for a given fiscal year is 50% of the national average weekly earnings of production or nonsupervisory workers on private, nonagricultural payrolls, as calculated by the Department, for the first three quarters of the preceding fiscal year.

MAXIMUM RATES

§ 702.805 What weekly maximum rates apply to compensation for permanent partial disability, temporary total disability, and temporary partial disability?

(a) The maximum rate in effect on the date of disability applies to all compensation payable for permanent partial disability, temporary partial disability, and temporary total disability.

(b) Examples:

(1) Employee *A* suffers a covered workplace injury on April 1, 2000, is temporarily totally disabled from that day through June 4, 2002, and is thereafter permanently partially disabled. All compensation payable for *A's* disability is subject to the FY 2000 maximum rate.

(2) Employee *B* suffers a covered workplace injury on August 25, 2010, and is temporarily totally disabled until September 25, 2010, when he returns to work. On January 3, 2011, he again becomes temporarily totally disabled from the same injury. He ceases work and is unable to return until November 22, 2012. All compensation payable for *B's* disability is subject to the FY 2010 maximum rate.

(3) Employee *C* retires on May 6, 2011. She discovers on November 10, 2012, that she has a compensable occupational disease. All compensation payable for *C's* occupational disease is subject to the FY 2013 maximum rate. *See* § 702.601(b) (occupational diseases discovered post-retirement are compensated as permanent partial disabilities).

§ 702.806 What weekly maximum rates apply to compensation for permanent total disability?

(a) The maximum rate in effect on the date that the employee became totally and permanently disabled applies to all compensation payable for permanent total disability during that fiscal year.

(b) For all periods the employee is permanently and totally disabled in subsequent fiscal years, the weekly compensation payable is subject to each subsequent year's maximum rate.

(c) If a claimant is receiving compensation for permanent total disability at the maximum rate for the current fiscal year, but the next fiscal year's maximum rate will be higher than the claimant's calculated compensation rate, the claimant's compensation for the next fiscal year will increase by the amount of the 10(f) adjustment, subject to the maximum rate for the next fiscal year.

(d) Examples:

(1) Employee *A* suffers a covered workplace injury on April 1, 2000, and is permanently and totally disabled from that date forward. *A's* compensation for the period from April 1, 2000, until September 30, 2000, is subject to the FY 2000 maximum rate. Beginning October 1, 2000, *A's* compensation for FY 2001 is subject to the FY 2001 maximum rate, compensation for FY 2002 is

subject to the FY 2002 maximum rate, *etc.*

(2) Employee *B* suffers a covered workplace injury on April 1, 2000, is temporarily totally disabled from that day through June 3, 2002, and is thereafter permanently totally disabled. *B's* compensation for the period from April 1, 2000, through June 3, 2002, is subject to the FY 2000 maximum rate (*see* § 702.805(a)). *B's* compensation for the period from June 4, 2002, through September 30, 2002, is subject to the FY 2002 maximum rate. Beginning October 1, 2002, *B's* compensation for FY 2003 is subject to the FY 2003 maximum rate, compensation for FY 2004 is subject to the FY 2004 maximum rate, *etc.*

(3) Employee *C* suffers a covered workplace injury in FY 2009 and is permanently totally disabled from that day forward. He was earning $1,950.00 a week when he was injured, making his calculated compensation rate $1,300.00 ($1,950.00 × 2 ÷ 3). His calculated compensation rate exceeds the maximum rate from FY 2009–2012; thus, his compensation is limited to each year's maximum rate. In FY 2013, *C's* calculated compensation rate of $1,300.00 is, for the first time, less than the FY 2013 maximum rate of $1,325.18. Applying the FY 2013 2.31% section 10(f) adjustment to *C's* FY 2012 compensation rate of $1,295.20 results in a compensation rate of $1,325.00 ($1,295.20 × .0231 = $29.92, rounded to the nearest cent; $1,295.20 + $29.92 = $1,325.12, rounded to the nearest dollar). This amount falls just below the FY 2013 maximum rate of $1,325.18. Thus, *C's* benefit rate for FY 2013 is $1,325.00, and is not limited by the maximum rate.

§ 702.807 What weekly maximum rates apply to death benefits?

(a) The maximum rate in effect on the date that the employee died applies to all death benefits payable during that fiscal year.

(b) Aggregate weekly death benefits paid to all eligible survivors during the fiscal year in which the employee died must not exceed the lower of—

(1) The maximum rate for that fiscal year; or

(2) The employee's average weekly wages.

(c) For subsequent fiscal years—

(1) Aggregate weekly death benefits paid during each subsequent fiscal year are subject to each subsequent year's maximum rate.

(2) If death benefits were paid in the first year at the employee's full average weekly wage under paragraph (b)(2) of this section, the aggregate weekly death benefits paid for each subsequent year may not exceed the current benefit rate plus the subsequent year's section 10(f) adjustment (*see* § 702.701).

(d) Post-retirement occupational diseases: Notwithstanding paragraphs (a) through (c) of this section, if an employee's death results from an occupational disease where the date of disability occurred after the employee voluntarily retired—

(1) Aggregate weekly death benefits paid to all eligible survivors during the fiscal year in which the employee died must not exceed the lower of:

(i) The maximum rate for that fiscal year; or

(ii) One fifty-second part of the employee's average annual earnings during the 52-week period preceding retirement.

(2) For subsequent fiscal years—

(i) Aggregate weekly death benefits paid during each subsequent fiscal year are subject to each subsequent year's maximum rate.

(ii) If death benefits were paid in the first year at 1/52 part of the employee's average annual earnings prior to retirement under paragraph (d)(1)(ii) of this section, the aggregate weekly death benefits paid for each subsequent year may not exceed the current benefit rate plus the subsequent year's section 10(f) adjustment (*see* § 702.701).

(e) Examples:

(1) Employee *A* suffers a covered workplace injury on May 1, 2013, and is permanently and totally disabled from that date until August 1, 2014, when he dies due to the injury. He has one eligible survivor and his average weekly wage at the time of injury was $3,000.00. The calculated compensation rate for *A's* survivor is $1,500.00 (*i.e.*, 50% of *A's* average weekly wage). *A's* weekly survivor's benefits for the period from August 2, 2014, to September 30, 2014, are limited to the FY 2014 maximum rate of $1,346.68. Beginning October 1, 2014, *A's* survivor's benefits for FY 2015 are

subject to the FY 2015 maximum rate, benefits for FY 2016 are subject to the FY 2016 maximum rate, *etc.*

(2) Employee *B* suffers a covered workplace injury and dies on December 1, 2012. She has one eligible survivor and her average weekly wage was $300.00. Because *B's* average weekly wage of $300.00 falls below the FY 2013 national average weekly wage of $662.59, death benefits are calculated at 50% of that national average wage (*see* 33 U.S.C. 909(e)). This yields a calculated compensation rate of $331.30. But because this rate exceeds *B's* actual average weekly wages, weekly death benefits payable during FY 2013 are limited to $300.00. In FY 2014, *B's* survivor is entitled to a 1.62% section 10(f) adjustment, resulting in weekly death benefits of $305.00 ($300.00 × .0162 = $4.86; $300.00 + $4.86 = $304.86, rounded to the nearest dollar). *B's* survivor would continue to receive section 10(f) adjustments in subsequent fiscal years.

(3) Employee *C* retired on February 1, 1998. During his last year of employment, he earned $23,000. He discovers on April 15, 2002, that he has a compensable occupational disease resulting in a 50% permanent impairment. *See* § 702.601(b). Because he retired more than one year before this date, his payrate for calculating compensation is the FY 2002 national average weekly wage, or $483.04. *See* § 702.603(b). He is entitled to weekly compensation of $161.01 ($483.04 × 2 ÷ 3 × 50%). *C* dies from the disease on June 1, 2015, leaving two survivors. The payrate for calculating death benefits is the FY 2015 national average weekly wage, or $688.51. *See* § 702.604(b). The survivors' aggregate calculated compensation rate is $459.01 ($688.51 × 2 ÷ 3). But because compensation cannot exceed 1/52 part of *C's* last year of earnings, aggregate weekly death benefits payable for FY 2015 are limited to $442.31 ($23,000 ÷ 52). For FY 2016, *C's* survivors are entitled to a 2.10% section 10(f) adjustment resulting in weekly death benefits of $452.00 ($442.31 × .021 = $9.29, rounded to the nearest cent; $442.31 + $9.29 = $451.60, rounded to the nearest dollar). *C's* survivors would continue to receive section 10(f) adjustments in subsequent fiscal years.

MINIMUM RATES

§ 702.808 What weekly minimum rates apply to compensation for partial disability?

There is no minimum rate for compensation paid for partial disability, whether temporary or permanent.

§ 702.809 What weekly minimum rates apply to compensation for temporary total disability?

(a) The minimum compensation payable for temporary total disability is the lower of:

(1) The minimum rate in effect on the date of disability, or

(2) The employee's average weekly wage on the date of disability.

(b) Example: Employee *A* suffers a covered workplace injury on May 6, 2014. He is temporarily totally disabled until November 6, 2015, when he returns to work. His average weekly wages at the time of disability were $500.00. Because his calculated compensation rate (*i.e.*, 66 and 2/3% of $500.00, or $333.34) is lower than the $336.67 FY 2014 minimum rate, *A's* compensation is raised to $336.67 for the entire period of his disability.

§ 702.810 What weekly minimum rates apply to compensation for permanent total disability?

(a) The weekly minimum compensation payable for the fiscal year in which the employee became permanently and totally disabled is the lower of:

(1) The minimum rate in effect on the date of disability, or

(2) The employee's average weekly wage on the date of disability.

(b) For all periods the employee is permanently and totally disabled in subsequent fiscal years, the weekly minimum compensation payable is the lower of:

(1) Each subsequent fiscal year's minimum rate, or

(2) The employee's average weekly wage on the date of disability.

(c) Example: Employee *A* suffers a covered workplace injury on April 1, 2003, and is permanently totally disabled from that day forward. He was earning $250.00 a week when he was injured. His calculated compensation rate is $166.67 ($250 × 2 ÷ 3). The FY 2003

minimum rate is $249.14. Because *A's* calculated compensation rate is below the FY 2003 minimum rate, and his actual weekly wage is above that rate, he is entitled to compensation at the minimum rate of $249.14 from April 1, 2003, to September 30, 2003. The FY 2004 minimum rate is $257.70. Because *A's* actual weekly wages on the date of disability are lower than the FY 2004 minimum rate, *A's* minimum weekly compensation rate for FY 2004 is $250.00. His weekly compensation rate for FY 2004, however, is higher because of a section 10(f) adjustment. For FY 2004, *A's* compensation rate is increased by a 3.44% section 10(f) adjustment, raising his compensation level to $258.00 ($249.14 × .0344 = $8.57; $249.14 + $8.57 = $257.71, rounded to the nearest dollar).

§ 702.811 What weekly minimum rates apply to death benefits?

(a) The average weekly wage used to compute death benefits is the greater of—

(1) The deceased employee's average weekly wages; or

(2) The national average weekly wage in effect at the time of the employee's death.

(b) The weekly minimum rate does not apply to death benefits.

PART 703—INSURANCE REGULATIONS

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AUTHORITY: 5 U.S.C. 301, and 8171 *et seq.;* 33 U.S.C. 901 *et seq.;* 42 U.S.C. 1651 *et seq.;* 43 U.S.C. 1333; Reorganization Plan No. 6 of 1950, 15 FR 3174, 64 Stat. 1263; Secretary's Order 10–2009, 74 FR 58834.

SOURCE: 38 FR 26873, Sept. 26, 1973, unless otherwise noted.

Subpart A—General

SOURCE: 70 FR 43233, July 26, 2005, unless otherwise noted.

§ 703.1 Scope of part.

Part 703 governs insurance carrier authorizations, insurance carrier security deposits, self-insurer authorizations, and certificates of compliance with the insurance regulations. These provisions are required by the LHWCA and apply to the extensions of the LHWCA except as otherwise provided in part 704 of this subchapter.

§ 703.2 Forms.

(a) Any information required by the regulations in this part to be submitted to OWCP must be submitted on forms the Director authorizes from time to time for such purpose. Persons submitting forms may not modify the forms or use substitute forms without OWCP's approval. These forms must be submitted, sent, or filed in the manner prescribed by OWCP.

Form No.	Title
(1) LS–271	Application for Self-Insurance.
(2) LS–274	Report of Injury Experience.
(3) LS–275 SI	Self-Insurer's Agreement and Undertaking.
(4) LS–275 IC	Insurance Carrier's Agreement and Undertaking.
(5) LS–276	Application for Security Deposit Determination.
(6) LS–405	Indemnity Bond.
(7) LS–570	Card Report of Insurance.

(b) Copies of the forms listed in this section are available for public inspection at the Office of Workers' Compensation Programs, U.S. Department of Labor, Washington, DC 20210. They may also be obtained from OWCP district offices and on the Internet at *http://www.dol.gov/owcp/dlhwc.*

[70 FR 43233, July 26, 2005, as amended at 77 FR 37286, June 21, 2012; 80 FR 12932, Mar. 12, 2015]

§ 703.3 Failure to secure coverage; penalties.

(a) Each employer must secure the payment of compensation under the Act either through an authorized insurance carrier or by becoming an authorized self-insurer under section 32(a)(1) or (2) of the Act (33 U.S.C. 932(a)(1) or (2)). An employer who fails to comply with these provisions is subject, upon conviction, to a fine of not more than $10,000, or by imprisonment for not more than one year, or both. Where the employer is a corporation, the president, secretary and treasurer each will also be subject to this fine and/or imprisonment, in addition to the fine against the corporation, and each is severally personally liable, jointly with the corporation, for all compensation or other benefits payable under the Act while the corporation fails to secure the payment of compensation.

(b) Any employer who willingly and knowingly transfers, sells, encumbers, assigns or in any manner disposes of, conceals, secretes, or destroys any property belonging to the employer after an employee sustains an injury covered by the Act, with the intent to avoid payment of compensation under

the Act to that employee or his/her dependents, shall be guilty of a misdemeanor and punished, upon conviction, by a fine of not more than $10,000 and/or imprisonment for one year. Where the employer is a corporation, the president, secretary and treasurer are also severally liable to imprisonment and, along with the corporation, jointly liable for the fine.

Subpart B—Authorization of Insurance Carriers

§ 703.101 Types of companies which may be authorized by the OWCP.

The OWCP will consider for the granting of authority to write insurance under the Longshoremen's and Harbor Workers' Compensation Act and its extensions the application of any stock company, mutual company or association, or any other person or fund, while authorized under the laws of the United States or for any State to insure workmen's compensation. The term ''carrier'' as used in this part means any person or fund duly authorized to insure workmen's compensation benefits under said Act, or its extensions.

§ 703.102 Applications for authority to write insurance; how filed; evidence to be submitted; other requirements.

An application for authority to write insurance under this Act shall be made in writing, signed by an officer of the applicant duly authorized to make such application, and transmitted to the Office of Workmen's Compensation Programs, U.S. Department of Labor, Washington, DC 20210. Such application shall be accompanied by full and complete information regarding the history and experience of such applicant in the writing of workmen's compensation insurance, together with evidence that it has authority in its charter or form of organization to write such insurance, and evidence that the applicant is currently authorized to insure workmen's compensation liability under the laws of the United States or of any State. The statements of fact in each application and in the supporting evidence shall be verified by the oath of the officer of the applicant who signs such application. Each applicant shall state in its application the area or areas, in which it intends to do business. In connection with any such application the following shall be submitted, the Office reserving the right to call for such additional information as it may deem necessary in any particular case:

(a) A copy of the last annual report made by the applicant to the insurance department or other authority of the State in which it is incorporated, or the State in which its principal business is done.

(b) A certified copy from the proper State authorities of the paper purporting to show the action taken upon such report, or such other evidence as the applicant desires to submit in respect of such report, which may obviate delay caused by an inquiry of the OWCP of the State authorities relative to the standing and responsibility of the applicant.

(c) A full and complete statement of its financial condition, if not otherwise shown, and, if a stock company, shall show specifically its capital stock and surplus.

(d) A copy of its charter or other formal outline of its organization, its rules, its bylaws, and other documents, writings, or agreements by and under which it does business, and such other evidence as it may deem proper to make a full exposition of its affairs and financial condition.

[38 FR 26873, Sept. 26, 1973; 50 FR 406, Jan. 3, 1985]

§ 703.103 Stock companies holding Treasury certificates of authority.

A stock company furnishing evidence that it is authorized to write workmen's compensation insurance under the laws of the United States or of any State, which holds a certificate of authority from the Secretary of the Treasury as an acceptable surety on Federal bonds, unless requested to do so, need not transmit to the Office with its application copies of such financial reports as are on file in the Department of the Treasury. The acceptance by that Department of such a company will be considered by the Office in conjunction with the application of such

company, provided there has been compliance with the other requirements of the regulations in this part.

§ 703.104 Applicants currently authorized to write insurance under the extensions of the LHWCA.

Any applicant currently authorized by the Office to write insurance under any extension of the LHWCA need not support its application under the LHWCA or any other LHWCA extension with the evidence required by the regulations in this part, except the form of policy and endorsement which it proposes to use, unless specifically requested by the Office, but instead its application may refer to the fact that it has been so authorized.

§ 703.105 Copies of forms of policies to be submitted with application.

With each application for authority to write insurance there shall be submitted for the approval of the Office copies of the forms of policies which the applicant proposes to issue in writing insurance under the LHWCA, or its extensions, to which shall be attached the appropriate endorsement to be used in connection therewith.

§ 703.106 Certificate of authority to write insurance.

No corporation, company, association, person, or fund shall write insurance under this Act without first having received from the OWCP a certificate of authority to write such insurance. Any such certificate issued by the Office, after application therefor in accordance with these regulations, may authorize the applicant to write such insurance in a limited territory as determined by the Office. Any such certificate may be suspended or revoked by the Office prior to its expiration for good cause shown, but no suspension or revocation shall affect the liability of any carrier already incurred. Good cause shall include, without limitation, the failure to maintain in such limited territory a regular business office with full authority to act on all matters falling within the Act, and the failure to promptly and properly perform the carrier's responsibilities under the Act and these regulations, with special emphasis upon lack of promptness in making payments when due, upon failure to furnish appropriate medical care, and upon attempts to offer to, or urge upon, claimants inequitable settlements. A hearing may be requested by the aggrieved party and shall be held before the Director or his representative prior to the taking of any adverse action under this section.

§ 703.108 Period of authority to write insurance.

Effective with the end of the authorization period July 1, 1983, through June 30, 1984, annual reauthorization of authority to write insurance coverage under the Act is no longer necessary. Beginning July 1, 1984, and thereafter, newly issued Certificates of Authority will show no expiration date. Certificates of Authority will remain in force for so long as the carrier complies with the requirements of the OWCP.

[50 FR 406, Jan. 3, 1985]

§ 703.109 Longshoremen's endorsement; see succeeding parts for endorsements for extensions.

(a) The following form of endorsement application to the standard workmen's compensation and employer's liability policy, shall be used, if required by the OWCP, with the form of policy approved by the Office for use by an authorized carrier:

For attachment to Policy No. ___,

The obligations of the policy include the Longshoremen's and Harbor Workers' Compensation Act, 33 U.S.C. 901 *et seq.*, and all laws amendatory thereof or supplementary thereto which may be or become effective while this policy is in force.

The company will be subject to the provisions of 33 U.S.C. 935. Insolvency or bankruptcy of the employer and/or discharge therein shall not relieve the company from payment of compensation and other benefits lawfully due for disability or death sustained by an employee during the life of the policy.

The company agrees to abide by all the provisions of this Act, and all lawful rules, regulations, orders, and decisions of the Office of Workmen's Compensation Programs, U.S. Department of Labor, unless and until set aside, modified, or reversed by appropriate appellate authority as provided for by said Act.

This endorsement shall not be cancelled prior to the date specified in this policy for its expiration until at least 30 days have elapsed after a notice of cancellation has

been sent to the District Director and to this employer.

All terms, conditions, requirements, and obligations, expressed in this policy or in any other endorsement attached thereto which are not inconsistent with or inapplicable to the provisions of this endorsement are hereby made a part of this endorsement as fully and completely as if wholly written herein.

§ 703.110 Other forms of endorsements and policies.

Where the form of endorsement prescribed by § 703.109 is not appropriate when used in conjunction with a form of policy approved for use by the Office no modification thereof shall be used unless specifically approved by the Office. Where the form of policy is designed to include therein the obligations of the insurer under said Act without the use of the appropriate endorsements, the policy shall contain the provisions required to be included in any of the endorsements. Such a policy, however, shall not be used until expressly approved by the Office.

§ 703.111 Submission of new forms of policies for approval; other endorsements.

No new forms of policies or modification of existing forms of policies shall be used by an insurer authorized by the Office under the regulations in this part to write insurance under said Act except after submission to and approval by the Office. No endorsement altering any provisions of a policy approved by the Office shall be used except after submission to and approval by the Office.

§ 703.112 Terms of policies.

A policy or contract of insurance shall be issued for the term of not less than 1 year from the date that it becomes effective, but if such insurance be not needed except for a particular contract or operation, the term of the policy may be limited to the period of such contract or operation.

§ 703.113 Marine insurance contracts.

A longshoremen's policy, or the longshoremen's endorsement provided for by § 703.109 for attachment to a marine policy, may specify the particular vessel or vessels in respect of which the policy applies and the address of the employer at the home port thereof. The report of the issuance of a policy or endorsement required by § 703.116 must be made to DLHWC and must show the name and address of the owner as well as the name or names of such vessel or vessels.

[80 FR 12933, Mar. 12, 2015]

§ 703.114 Notice of cancellation.

Cancellation of a contract or policy of insurance issued under authority of the Act will not become effective otherwise than as provided by 33 U.S.C. 936(b); 30 days before such cancellation is intended to be effective, notice of a proposed cancellation must be given to the district director and the employer in accordance with the provisions of 33 U.S.C. 912(c). The notice requirements of 33 U.S.C. 912(c) will be considered met when:

(a) Notice to the district director is given by a method specified in § 702.101(a) of this chapter or in the same manner that reports of issuance of policies and endorsements are reported under § 703.116; and

(b) Notice to the employer is given by a method specified in § 702.101(b) of this chapter.

[80 FR 12933, Mar. 12, 2015]

§ 703.115 Discharge by the carrier of obligations and duties of employer.

Every obligation and duty in respect of payment of compensation, the providing of medical and other treatment and care, the payment or furnishing of any other benefit required by said Act and in respect of the carrying out of the administrative procedure required or imposed by said Act or the regulations in this part upon an employer shall be discharged and carried out by the carrier except that the prescribed report of injury or death shall be sent by the employer to the district director and to the insurance carrier as required by 33 U.S.C. 930. Such carrier shall be jointly responsible with the employer for the submission of all reports, notices, forms, and other administrative papers required by the district director or the Office in the administration of said Act to be submitted by the employer, but any form

or paper so submitted where required therein shall contain in addition to the name and address of the carrier, the full name and address of the employer on whose behalf it is submitted. Notice to or knowledge of an employer of the occurrence of the injury or death shall be notice to or knowledge of such carrier. Jurisdiction of the employer by a district director, the Office, or appropriate appellate authority under said Act shall be jurisdiction of such carrier. Any requirement under any compensation order, finding, or decision shall be binding upon such carrier in the same manner and to the same extent as upon the employer.

§ 703.116 Report by carrier of issuance of policy or endorsement.

Each carrier must report to DLHWC each policy and endorsement issued by it to an employer whose employees are engaging in work subject to the Act and its extensions. Such reports must be made in a manner prescribed by OWCP. Reports made to an OWCP-authorized intermediary, such as an industry data collection organization, satisfy this reporting requirement.

[80 FR 12933, Mar. 12, 2015]

§ 703.117 Report; by whom sent.

The report of issuance of a policy and endorsement provided for in § 703.116 or notice of cancellation provided for in § 703.114 must be sent by the home office of the carrier, except that any carrier may authorize its agency or agencies in any compensation district to make such reports, provided the carrier notifies DLHWC of the agencies so duly authorized.

[80 FR 12933, Mar. 12, 2015]

§ 703.118 Agreement to be bound by report.

Every applicant for the authority to write insurance under the provisions of this Act, will be deemed to have included in its application an agreement that the acceptance by DLHWC of a report of insurance, as provided for by § 703.116, binds the carrier to full liability for the obligations under this Act of the employer named in said report, and every certificate of authority to write insurance under this Act will be deemed to have been issued by the Office upon consideration of the carrier's agreement to become so bound. It will be no defense to this agreement that the carrier failed or delayed to issue the policy to the employer covered by this report.

[80 FR 12933, Mar. 12, 2015]

§ 703.119 [Reserved]

§ 703.120 Name of one employer only in each report.

For policies that are reported to DLHWC on Form LS–570 (Carrier's Report of Issuance of Policy), a separate report of the issuance of a policy and endorsement, provided for by § 703.116, must be made for each employer covered by a policy. If a policy is issued insuring more than one employer, a separate form LS–570 for each employer so covered must be sent to DLHWC in the manner described in § 703.116, with the name of only one employer on each form.

[80 FR 12933, Mar. 12, 2015]

Subpart C—Insurance Carrier Security Deposit Requirements

SOURCE: 70 FR 43234, July 26, 2005, unless otherwise noted.

§ 703.201 Deposits of security by insurance carriers.

The regulations in this subpart require certain insurance carriers to deposit security in the form of indemnity bonds, letters of credit or negotiable securities (chosen at the option of the carrier) of a kind and in an amount determined by the Office, and prescribe the conditions under which deposits must be made. Security deposits secure the payment of compensation and medical benefits when an insurance carrier defaults on any of its obligations under the LHWCA, regardless of the date such obligations arose. They also secure the payment of compensation and medical benefits when a carrier becomes insolvent and such obligations are not otherwise fully secured by a State guaranty fund. Any gap in State guaranty fund coverage will have a direct effect on the amount of security the Office will require a carrier to post.

As used in this subpart, the terms ''obligations under the Act'' and ''LHWCA obligations'' mean a carrier's liability for compensation payments and medical benefits arising under the Longshore and Harbor Workers' Compensation Act and any of its extensions.

§ 703.202 Identification of significant gaps in State guaranty fund coverage for LHWCA obligations.

(a) In determining the amount of a carrier's required security deposit, the Office will consider the extent to which a State guaranty fund secures the insurance carrier's LHWCA obligations in that State. When evaluating State guaranty funds, the Office may consider a number of factors including, but not limited to—

(1) Limits on weekly benefit amounts;

(2) Limits on aggregate maximum benefit amounts;

(3) Time limits on coverage;

(4) Ocean marine exclusions;

(5) Employer size and viability provisions; and

(6) Financial strength of the State guaranty fund itself.

(b) OWCP will identify States without guaranty funds and States with guaranty funds that do not fully and immediately secure LHWCA obligations and will post its findings on the Internet at *http://www.dol.gov/owcp/dlhwc*. These findings will indicate the extent of any partial or total gap in coverage provided by a State guaranty fund, and they will be open for inspection and comment by all interested parties. If the extent of coverage a particular State guaranty fund provides either cannot be determined or is ambiguous, OWCP will deem one third (33⅓ percent) of a carrier's LHWCA obligations in that State to be unsecured. OWCP will revise its findings from time to time, in response to substantiated public comments it receives or for any other reasons it considers relevant.

[70 FR 43234, July 26, 2005, as amended at 77 FR 37286, June 21, 2012]

§ 703.203 Application for security deposit determination; information to be submitted; other requirements.

(a) Each insurance carrier authorized by OWCP to write insurance under the LHWCA or any of its extensions, and each insurance carrier seeking initial authorization to write such insurance, must apply annually, on a schedule set by OWCP, for a determination of the extent of its unsecured obligations and the security deposit required. The application must be addressed to the Branch of Financial Management and Insurance (Branch) within OWCP's Division of Longshore and Harbor Workers' Compensation, and be made on a form provided by OWCP. The application must contain the following:

(1) Any carrier seeking an exemption from the security deposit requirements based on its financial standing (*see* § 703.204(c)(1)) must submit documentation establishing the carrier's current rating and its rating for the immediately preceding year from each insurance rating service designated by the Branch and posted on the Internet at *http://www.dol.gov/owcp/dlhwc*.

(2) All other carriers, and any carrier whose exemption request under paragraph (a)(1) of this section has been denied, must provide—

(i) A statement of the carrier's outstanding liabilities under the LHWCA or any of its extensions for its LHWCA obligations for each State in which the obligations arise; and

(ii) Any other information the Branch requests to enable it to give the application adequate consideration including, but not limited to, the reports set forth at § 703.212.

(b) If the carrier disagrees with any of OWCP's findings regarding State guaranty funds made under § 703.202(b) as they exist when it submits its application, the carrier may submit a statement of its unsecured obligations based on a different conclusion regarding the extent of coverage afforded by one or more State guaranty funds. The carrier must submit evidence and/or argument with its application sufficient to establish that such conclusion is correct.

(c) The carrier must sign and swear to the application. If the carrier is not an individual, the carrier's duly authorized officer must sign and swear to

the application and list his or her official designation. If the carrier is a corporation, the officer must also affix the corporate seal.

(d) At any time after filing an application, the carrier must inform the Branch immediately of any material changes that may have rendered its application incomplete, inaccurate or misleading.

(e) By filing an application, the carrier consents to be bound by and to comply with the regulations and requirements in this part.

[70 FR 43234, July 26, 2005, as amended at 77 FR 37286, June 21, 2012]

§ 703.204 Decision on insurance carrier's application; minimum amount of deposit.

(a) The Branch will issue a decision on the application determining the extent of an insurance carrier's unsecured LHWCA obligations and fixing the amount of security the carrier must deposit to fully secure payment of its unsecured obligations. The Branch will transmit its decision to the applicant in a way it considers appropriate.

(b) The Branch may consider a number of factors in setting the security deposit amount including, but not limited to, the—

(1) Financial strength of the carrier as determined by private insurance rating organizations;

(2) Financial strength of the carrier's insureds in the Longshore industry;

(3) Extent to which State guaranty funds secure the carrier's LHWCA obligations in the event the carrier defaults on its obligations or becomes insolvent;

(4) Carrier's longevity in writing LHWCA or other workers' compensation coverage;

(5) Extent of carrier's exposure for LHWCA coverage; and

(6) Carrier's payment history in satisfying its LHWCA obligations.

(c) In setting the security deposit amount, the Branch will follow these criteria:

(1) Carriers who hold the highest rating awarded by each of the three insurance rating services designated by the Branch and posted on the Internet at *http://www.dol.gov/owcp/dlhwc* for both the current rating year and the immediately preceding year will not be required to deposit security.

(2) Carriers whose LHWCA obligations are fully secured by one or more State guaranty funds, as evaluated by OWCP under § 703.202 of this subpart, will not be required to deposit security.

(3) The Branch will require all carriers not meeting the requirements of paragraphs (c)(1) or (2) of this section to deposit security for their LHWCA obligations not secured by a State guaranty fund, as evaluated by OWCP under § 703.202 of this subpart. For carriers that write only an insignificant or incidental amount of LHWCA insurance, the Branch will require a deposit in an amount determined by the Branch from time to time. For all other carriers, the Branch will require a minimum deposit of one third (33⅓ percent) of a carrier s outstanding LHWCA obligations not secured by a State guaranty fund, but may require a deposit up to an amount equal to the carrier's total outstanding LHWCA obligations (100 percent) not secured by a State guaranty fund.

(d) If a carrier believes that a lesser deposit would fully secure its LHWCA obligations, the carrier may request a hearing before the Director of the Division of Longshore and Harbor Workers' Compensation (Longshore Director) or the Longshore Director's representative. Requests for hearing must be in writing and sent to the Branch within 10 days of the date of the Branch's decision. The carrier may submit new evidence and/or argument in support of its challenge to the Branch's decision and must provide any additional documentation OWCP requests. The Longshore Director or his representative will notify the carrier of the hearing date within 10 days of receiving the request. The Longshore Director or his representative will issue the final agency decision on the application within 60 days of the hearing date, or, where evidence is submitted after the hearing, within 60 days of the receipt of such evidence, but no later than 180 days after receiving the carrier's request for a hearing.

[70 FR 43234, July 26, 2005, as amended at 77 FR 37286, June 21, 2012]

§ 703.205 Filing of Agreement and Undertaking; deposit of security.

Within 45 days of the date on which the insurance carrier receives the Branch's decision (or, if the carrier requests a hearing, a period set by the Longshore Director or the Longshore Director's representative) determining the extent of its unsecured LHWCA obligations and fixing the required security deposit amount (*see* § 703.204), the carrier must:

(a) Execute and file with the Branch an Agreement and Undertaking, in a form prescribed and provided by OWCP, in which the carrier shall agree to—

(1) Deposit with the Branch indemnity bonds or letters of credit in the amount fixed by the Office, or deposit negotiable securities under §§ 703.207 and 703.208 in that amount;

(2) Authorize the Branch, at its discretion, to bring suit under any deposited indemnity bond or to draw upon any deposited letters of credit, as appropriate under the terms of the security instrument, or to collect the interest and principal as they become due on any deposited negotiable securities and to sell or otherwise liquidate such negotiable securities or any part thereof when—

(i) The carrier defaults on any of its LHWCA obligations;

(ii) The carrier fails to renew any deposited letter of credit or substitute a new letter of credit, indemnity bond or acceptable negotiable securities in its place;

(iii) The carrier fails to renew any deposited negotiable securities at maturity or substitute a letter of credit, indemnity bond or acceptable negotiable securities in their place;

(iv) State insolvency proceedings are initiated against the carrier; or

(v) The carrier fails to comply with any of the terms of the Agreement and Undertaking; and

(3) Authorize the Branch, at its discretion, to pay such ongoing claims of the carrier as it may find to be due and payable from the proceeds of the deposited security;

(b) Give security in the amount fixed in the Office's decision:

(1) In the form of an indemnity bond with sureties satisfactory to the Branch and in such form, and containing such provisions, as the Branch may prescribe: *Provided*, That only surety companies approved by the United States Treasury Department under the laws of the United States and the rules and regulations governing bonding companies may act as sureties on such indemnity bonds (*see* Department of Treasury's Circular–570), and that a surety company that is a corporate subsidiary of an insurance carrier may not act as surety on such carrier's indemnity bond;

(2) In the form of letters of credit issued by a financial institution satisfactory to the Branch and upon which the Branch may draw; or

(3) By a deposit of negotiable securities with a Federal Reserve Bank or the Treasurer of the United States in compliance with §§ 703.207 and 703.208.

§ 703.206 [Reserved]

§ 703.207 Kinds of negotiable securities that may be deposited; conditions of deposit; acceptance of deposits.

An insurance carrier electing to deposit negotiable securities to secure its obligations under the Act in the amount fixed by the Office under the regulations in this part shall deposit any negotiable securities acceptable as security for the deposit of public monies of the United States under regulations issued by the Secretary of the Treasury. (*See* 31 CFR part 225.) The approval, valuation, acceptance, and custody of such securities is hereby committed to the several Federal Reserve Banks and the Treasurer of the United States.

§ 703.208 Deposits of negotiable securities with Federal Reserve banks or the Treasurer of the United States; interest thereon.

Deposits of negotiable securities provided for by the regulations in this part must be made with any Federal Reserve bank or any branch of a Federal Reserve bank designated by the Branch, or the Treasurer of the United States, and must be held subject to the order of the Branch. The Branch will authorize the insurance carrier to collect interest on the securities it deposits unless any of the conditions set forth at § 703.211(a) occur.

§ 703.209 Substitution and withdrawal of indemnity bond, letters of credit or negotiable securities.

(a) A carrier may not substitute other security for any indemnity bond or letters of credit deposited under the regulations in this part except when authorized by the Branch. A carrier may, however, substitute negotiable securities acceptable under the regulations in this part for previously-deposited negotiable securities without the Branch's prior approval.

(b) A carrier that has ceased to write insurance under the Act may apply to the Branch for withdrawal of its security deposit. The carrier must file with its application a sworn statement setting forth—

(1) A list of all cases in each State in which the carrier is paying compensation, together with the names of the employees and other beneficiaries, a description of causes of injury or death, and a statement of the amount of compensation paid;

(2) A similar list of all pending cases in which the carrier has not yet paid compensation; and

(3) A similar list of all cases in which injury or death has occurred within one year before such application or in which the last payment of compensation was made within one year before such application.

(c) The Branch may authorize withdrawal of previously-deposited indemnity bonds, letters of credit and negotiable securities that, in the opinion of the Branch, are not necessary to provide adequate security for the payment of the carrier's outstanding and potential LHWCA liabilities. No withdrawals will be authorized unless there has been no claim activity involving the carrier for a minimum of five years, and the Branch is reasonably certain that no further claims will arise.

§ 703.210 Increase or reduction in security deposit amount.

(a) Whenever the Office considers the security deposited by an insurance carrier insufficient to fully secure the carrier's LHWCA obligations, the carrier must, upon demand by the Branch, deposit additional security in accordance with the regulations in this part in an amount fixed by the Branch. The Branch will issue its decision requiring additional security in accordance with § 703.204, and the procedures set forth at §§ 703.204(d) and 703.205 for requesting a hearing and complying with the Office's decision will apply as appropriate.

(b) The Branch may reduce the required security at any time on its own initiative, or upon application of a carrier, when in the Branch's opinion the facts warrant a reduction. A carrier seeking a reduction must furnish any information the Office requests regarding its outstanding LHWCA obligations for any State in which it does business, its obligations not secured by a State guaranty fund in each of these States, and any other evidence as the Branch considers necessary.

§ 703.211 Authority to seize security deposit; use and/or return of proceeds.

(a) The Office may take any of the actions set forth in paragraph (b) of this section when an insurance carrier—

(1) Defaults on any of its LHWCA obligations;

(2) Fails to renew any deposited letter of credit or substitute a new letter of credit, indemnity bond or acceptable negotiable securities in its place;

(3) Fails to renew any deposited negotiable securities at maturity or substitute a letter of credit, indemnity bond or acceptable negotiable securities in their place;

(4) Has State insolvency proceedings initiated against it; or

(5) Fails to comply with any of the terms of the Agreement and Undertaking.

(b) When any of the conditions set forth in paragraph (a) of this section occur, the Office may, within its discretion and as appropriate to the security instrument—

(1) Bring suit under any indemnity bond;

(2) Draw upon any letters of credit;

(3) Seize any negotiable securities, collect the interest and principal as they may become due, and sell or otherwise liquidate the negotiable securities or any part thereof.

(c) When the Office, within its discretion, determines that it no longer

needs to collect the interest and principal of any negotiable securities seized pursuant to paragraphs (a) and (b) of this section, or to retain the proceeds of their sale, it must return any of the carrier's negotiable securities still in its possession and any remaining proceeds of their sale.

§ 703.212 Required reports; examination of insurance carrier accounts.

(a) Upon the Office's request, each insurance carrier must submit the following reports:

(1) A certified financial statement of the carrier's assets and liabilities, or a balance sheet.

(2) A sworn statement showing the extent of the carrier's unsecured LHWCA obligations for each State in which it is authorized to write insurance under the LHWCA or any of its extensions.

(3) A sworn statement reporting the carrier's open cases as of the date of such report, listing by State all death and injury cases, together with a report of the status of all outstanding claims.

(b) Whenever it considers necessary, the Office may inspect or examine a carrier's books of account, records, and other papers to verify any financial statement or other information the carrier furnished to the Office in any statement or report required by this section, or any other section of the regulations in this part. The carrier must permit the Office or its duly authorized representative to make the inspection or examination. Alternatively, the Office may accept an adequate independent audit by a certified public accountant.

§ 703.213 Failure to comply.

The Office may suspend or revoke a carrier's certificate of authority to write LHWCA insurance under § 703.106 when the carrier fails to comply with any of the requirements of this part.

Subpart D—Authorization of Self-Insurers

SOURCE: 70 FR 43234, July 26, 2005, unless otherwise noted.

§ 703.301 Employers who may be authorized as self-insurers.

The regulations in this subpart set forth procedures for authorizing employers to self-insure the payment of compensation under the Longshore and Harbor Workers' Compensation Act, or its extensions. The Office may authorize any employer to self-insure who, pursuant to the regulations in this part, furnishes to the Office satisfactory proof of its ability to pay compensation directly, and who agrees to immediately cancel any existing insurance policy covering its Longshore obligations (except for excess or catastrophic workers' compensation insurance, *see* §§ 703.302(a)(6), 703.304(a)(6)) when OWCP approves the employer's application to be self-insured. The regulations require self-insurers to deposit security in the form of an indemnity bond, letters of credit or negotiable securities (at the option of the employer) of a kind and in an amount determined by the Office, and prescribe the conditions under which such deposits shall be made. The term ''self-insurer'' as used in these regulations means any employer securing the payment of compensation under the LHWCA or its extensions in accordance with the provisions of 33 U.S.C. 932(a)(2) and these regulations.

§ 703.302 Application for authority to become a self-insurer; how filed; information to be submitted; other requirements.

(a) Any employer may apply to become an authorized self-insurer. The application must be addressed to the Branch of Financial Management and Insurance (Branch) within OWCP's Division of Longshore and Harbor Workers' Compensation, and be made on a form provided by OWCP. The application must contain—

(1) A statement of the employer's total payroll for the 12 months before the application date;

(2) A statement of the average number of employees engaged in employment within the purview of the LHWCA or any of its extensions for the 12 months before the application date;

(3) A statement of the number of injuries to such employees resulting in

disability of more than 7 days' duration, or in death, during each of the 5 years before the application date;

(4) A certified financial report for each of the three years before the application date;

(5) A description of the facilities maintained or the arrangements made for the medical and hospital care of injured employees;

(6) A statement describing the provisions and maximum amount of any excess or catastrophic insurance; and

(7) Any other information the Branch requests to enable it to give the application adequate consideration including, but not limited to, the reports set forth at § 703.310.

(b) The employer must sign and swear to the application. If the employer is not an individual, the employer's duly authorized officer must sign and swear to the application and list his or her official designation. If the employer is a corporation, the officer must also affix the corporate seal.

(c) At any time after filing an application, the employer must inform the Branch immediately of any material changes that may have rendered its application incomplete, inaccurate or misleading.

(d) By filing an application, the employer consents to be bound by and to comply with the regulations and requirements in this part.

§ 703.303 Decision on employer's application.

(a) The Branch will issue a decision granting or denying the employer's application to be an authorized self-insurer. If the Branch grants the application, the decision will fix the amount of security the employer must deposit. The Branch will transmit its decision to the employer in a way it considers appropriate.

(b) The employer is authorized to self-insure beginning with the date of the Branch's decision. Each grant of authority to self-insure is conditioned, however, upon the employer's execution and filing of an Agreement and Undertaking and deposit of the security fixed in the decision in the form and within the time limits required by § 703.304. In the event the employer fails to comply with the requirements set forth in § 703.304, its authorization to self-insure will be considered never to have been effective, and the employer will be subject to appropriate penalties for failure to secure its LHWCA obligations.

(c) The Branch will require security in the amount it considers necessary to fully secure the employer's LHWCA obligations. When fixing the amount of security, the Branch may consider a number of factors including, but not limited to, the—

(1) Employer's overall financial standing;

(2) Nature of the employer's work;

(3) Hazard of the work in which the employees are employed;

(4) Employer's payroll amount for employees engaged in employment within the purview of the Act; and

(5) Employer's accident record as shown in the application and the Office's records.

(d) If an employer believes that the Branch incorrectly denied its application to self-insure, or that a lesser security deposit would fully secure its LHWCA obligations, the employer may request a hearing before the Director of the Division of Longshore and Harbor Workers' Compensation (Longshore Director) or the Longshore Director's representative. Requests for hearing must be in writing and sent to the Branch within ten days of the date of the Branch's decision. The employer may submit new evidence and/or argument in support of its challenge to the Branch's decision and must provide any additional documentation OWCP requests. The Longshore Director or his representative will notify the employer of the hearing date within 10 days of receiving the request. The Longshore Director or his representative will issue the final agency decision on the application within 60 days of the hearing date, or, where evidence is submitted after the hearing, within 60 days of the receipt of such evidence, but no later than 180 days after receiving the employer's request for a hearing.

§ 703.304 Filing of Agreement and Undertaking; deposit of security.

Within 45 days of the date on which the employer receives the Branch's decision (or, if the employer requests a hearing, a period set by the Longshore Director or the Longshore Director's representative) granting its application to self-insure and fixing the required security deposit amount (*see* § 703.303), the employer must:

(a) Execute and file with the Branch an Agreement and Undertaking, in a form prescribed and provided by OWCP, in which the employer shall agree to:

(1) Pay when due, as required by the provisions of the Act, all compensation payable on account of injury or death of any of its employees injured within the purview of the Act;

(2) Furnish medical, surgical, hospital, and other attendance, treatment and care as required by the Act;

(3) Deposit with the Branch indemnity bonds or letters of credit in the amount fixed by the Office, or deposit negotiable securities under §§ 703.306 and 703.307 in that amount;

(4) Authorize the Branch, at its discretion, to bring suit under any deposited indemnity bond or to draw upon any deposited letters of credit, as appropriate under the terms of the security instrument, or to collect the interest and principal as they become due on any deposited negotiable securities and to seize and sell or otherwise liquidate such negotiable securities or any part thereof when the employer:

(i) Defaults on any of its LHWCA obligations;

(ii) Fails to renew any deposited letter of credit or substitute a new letter of credit, indemnity bond or acceptable negotiable securities in its place;

(iii) Fails to renew any deposited negotiable securities at maturity or substitute a letter of credit, indemnity bond or acceptable negotiable securities in their place; or

(iv) Fails to comply with any of the terms of the Agreement and Undertaking;

(5) Authorize the Branch, at its discretion, to pay such compensation, medical, and other expenses and any accrued penalties imposed by law as it may find to be due and payable from the proceeds of the deposited security; and

(6) Obtain and maintain, if required by the Office, excess or catastrophic insurance in amounts to be determined by the Office.

(b) Give security in the amount fixed in the Office's decision:

(1) In the form of an indemnity bond with sureties satisfactory to the Office, and in such form and containing such provisions as the Office may prescribe: *Provided*, That only surety companies approved by the United States Treasury Department under the laws of the United States and the rules and regulations governing bonding companies may act as sureties on such indemnity bonds (*see* Department of Treasury's Circular–570);

(2) In the form of letters of credit issued by a financial institution satisfactory to the Branch and upon which the Branch may draw; or,

(3) By a deposit of negotiable securities with a Federal Reserve Bank or the Treasurer of the United States in compliance with §§ 703.306 and 703.307.

§ 703.305 [Reserved]

§ 703.306 Kinds of negotiable securities that may be deposited; conditions of deposit; acceptance of deposits.

A self-insurer or a self-insurer applicant electing to deposit negotiable securities to secure its obligations under the Act in the amount fixed by the Office under the regulations in this part shall deposit any negotiable securities acceptable as security for the deposit of public monies of the United States under regulations issued by the Secretary of the Treasury. (*See* 31 CFR part 225.) The approval, valuation, acceptance, and custody of such securities is hereby committed to the several Federal Reserve Banks and the Treasurer of the United States.

§ 703.307 Deposits of negotiable securities with Federal Reserve banks or the Treasurer of the United States; interest thereon.

Deposits of negotiable securities provided for by the regulations in this part shall be made with any Federal Reserve bank or any branch of a Federal Reserve bank designated by the Office, or the Treasurer of the United

States, and shall be held subject to the order of the Office. The Office will authorize the self-insurer to collect interest on the securities deposited by it unless any of the conditions set forth at §703.304(a)(4) occur.

§ 703.308 Substitution and withdrawal of indemnity bond, letters of credit or negotiable securities.

(a) A self-insurer may not substitute other security for any indemnity bond or letters of credit deposited under the regulations in this part except when authorized by the Office. A self-insurer may, however, substitute negotiable securities acceptable under the regulations in this part for previously-deposited negotiable securities without the Office's prior approval.

(b) A self-insurer discontinuing business, discontinuing operations within the purview of the Act, or securing the payment of compensation by commercial insurance under the provisions of the Act may apply to the Office for the withdrawal of the security it provided under the regulations in this part. The self-insurer must file with its application a sworn statement setting forth—

(1) A list of all cases in each compensation district in which the self-insurer is paying compensation, together with the names of the employees and other beneficiaries, a description of causes of injury or death, and a statement of the amount of compensation paid;

(2) A similar list of all pending cases in which the self-insurer has not yet paid compensation; and

(3) A similar list of all cases in which injury or death has occurred within one year before such application or in which the last payment of compensation was made within one year before such application.

(c) The Office may authorize withdrawal of previously-deposited indemnity bonds, letters of credit and negotiable securities that, in the opinion of the Office, are not necessary to provide adequate security for the payment of the self-insurer's outstanding and potential LHWCA obligations. No withdrawals will be authorized unless there has been no claim activity involving the self-insurer for a minimum of five years, and the Office is reasonably certain no further claims will arise.

§ 703.309 Increase or reduction in the amount of indemnity bond, letters of credit or negotiable securities.

(a) Whenever the Office considers the principal sum of the indemnity bond or letters of credit filed or the amount of the negotiable securities deposited by a self-insurer insufficient to fully secure the self-insurer's LHWCA obligations, the self-insurer must, upon demand by the Office, deposit additional security in accordance with the regulations in this part in an amount fixed by the Branch. The Branch will issue its decision requiring additional security in accordance with §703.303, and the procedures set forth at §§703.303(d) and 703.304 for requesting a hearing and complying with the Office's decision will apply as appropriate.

(b) The Office may reduce the required security at any time on its own initiative, or upon application of a self-insurer, when in the Office's opinion the facts warrant a reduction. A self-insurer seeking a reduction must furnish any information the Office requests regarding its current affairs, the nature and hazard of the work of its employees, the amount of its payroll for employees engaged in maritime employment within the purview of the Act, its financial condition, its accident experience, a record of compensation payments it has made, and any other evidence the Branch considers necessary.

§ 703.310 Authority to seize security deposit; use and/or return of proceeds.

(a) The Office may take any of the actions set forth in paragraph (b) of this section when a self-insurer—

(1) Defaults on any of its LHWCA obligations;

(2) Fails to renew any deposited letter of credit or substitute a new letter of credit, indemnity bond or acceptable negotiable securities in its place;

(3) Fails to renew any deposited negotiable securities at maturity or substitute a letter of credit, indemnity bond or acceptable negotiable securities in their place; or

(4) Fails to comply with any of the terms of the Agreement and Undertaking.

(b) When any of the conditions set forth in paragraph (a) of this section occur, the Office may, within its discretion and as appropriate to the security instrument—

(1) Bring suit under any indemnity bond;

(2) Draw upon any letters of credit;

(3) Seize any negotiable securities, collect the interest and principal as they may become due, and sell or otherwise liquidate the negotiable securities or any part thereof.

(c) When the Office, within its discretion, determines that it no longer needs to collect the interest and principal of any negotiable securities seized pursuant to paragraphs (a) and (b) of this section, or to retain the proceeds of their sale, it must return any of the employer's negotiable securities still in its possession and any remaining proceeds of their sale.

§ 703.311 Required reports; examination of self-insurer accounts.

(a) Upon the Office's request, each self-insurer must submit the following reports:

(1) A certified financial statement of the self-insurer's assets and liabilities, or a balance sheet.

(2) A sworn statement showing by classifications the payroll of employees of the self-insurer who are engaged in employment within the purview of the LHWCA or any of its extensions.

(3) A sworn statement covering the six-month period preceding the date of such report, listing by compensation districts all death and injury cases which have occurred during such period, together with a report of the status of all outstanding claims showing the particulars of each case.

(b) Whenever it considers necessary, the Office may inspect or examine a self-insurer's books of account, records, and other papers to verify any financial statement or other information the self-insurer furnished to the Office in any report required by this section, or any other section of the regulations in this part. The self-insurer must permit the Office or its duly authorized representative to make the inspection or examination. Alternatively, the Office may accept an adequate report of a certified public accountant.

§ 703.312 Period of authorization as self-insurer.

(a) Self-insurance authorizations will remain in effect for so long as the self-insurer complies with the requirements of the Act, the regulations in this part, and OWCP.

(b) A self-insurer who has secured its liability by depositing an indemnity bond with the Office will, on or about May 10 of each year, receive from the Office a form for executing a bond that will continue its self-insurance authorization. The submission of such bond, duly executed in the amount indicated by the Office, will be deemed a condition of the continuing authorization.

§ 703.313 Revocation of authorization to self-insure.

The Office may for good cause shown suspend or revoke the authorization of any self-insurer. Failure by a self-insurer to comply with any provision or requirement of law or of the regulations in this part, or with any lawful order or communication of the Office, or the failure or insolvency of the surety on its indemnity bond, or impairment of financial responsibility of such self-insurer, shall be deemed good cause for suspension or revocation.

Subpart E—Issuance of Certificates of Compliance

§ 703.501 Issuance of certificates of compliance.

Every employer who has secured the payment of compensation as required by 33 U.S.C. 932 and by the regulations in this part may request a certificate from the district director in the compensation district in which he has operations, and for which a certificate is required by 33 U.S.C. 937, showing that such employer has secured the payment of compensation. Only one such certificate will be issued to an employer in a compensation district, and it will be valid only during the period for which such employer has secured such payment. An employer so desiring may have photocopies of such a certificate made for use in different places

within the compensation district. Two forms of such certificates have been provided by the Office, one form for use where the employer has obtained insurance generally under these regulations, and one for use where the employer has been authorized as a self-insurer.

§ 703.502 [Reserved]

§ 703.503 Return of certificates of compliance.

Upon the termination by expiration, cancellation or otherwise, of a policy of insurance issued under the provisions of law and these regulations, or the revocation or termination of the privilege of self-insurance granted by the Office, all certificates of compliance issued on the basis of such insurance or self-insurance shall be void and shall be returned by the employer to the district director issuing them with a statement of the reason for such return. An employer holding certificate of compliance under an insurance policy which has expired, pending renewal of such insurance need not return such certificate of compliance if such expired insurance is promptly replaced. An employer who has secured renewal of insurance upon the expiration of policy under said Act or whose self-insurance thereunder is reauthorized without a break in the continuity thereof need not return an expired certificate of compliance.

PART 704—SPECIAL PROVISIONS FOR LHWCA EXTENSIONS

Sec.

704.001 Extensions covered by this part.
704.002 Scope of part.

DEFENSE BASE ACT

704.101 Administration; compensation districts.
704.102 Commutation of payments to aliens and nonresidents.
704.103 Removal of certain minimums when computing or paying compensation.
704.151 DBA endorsement.

DISTRICT OF COLUMBIA WORKMEN'S COMPENSATION ACT

704.201 Administration; compensation districts.
704.251 DCCA endorsement.

OUTER CONTINENTAL SHELF LANDS ACT

704.301 Administration; compensation districts.
704.351 OCSLA endorsement.

NONAPPROPRIATED FUND INSTRUMENTALITIES ACT

704.401 Administration; compensation districts.
704.451 NFIA endorsement.

AUTHORITY: 5 U.S.C. 301; Reorg. Plan No. 6 of 1950, 15 FR 3174, 64 Stat. 1263; 33 U.S.C. 939; 36 D.C. Code 501 *et seq.;* 42 U.S.C. 1651 *et seq.;* 43 U.S.C. 1331; 5 U.S.C. 6171 *et seq.;* Secretary's Order 1–89; Employment Standards Order No. 90–02.

SOURCE: 38 FR 26877, Sept. 26, 1973, unless otherwise noted.

§ 704.001 Extensions covered by this part.

(a) Defense Base Act (DBA).

(b) District of Columbia Workmen's Compensation Act (DCCA).

(c) Outer Continental Shelf Lands Act (OCSLA).

(d) Nonappropriated Fund Instrumentalities Act (NFIA).

§ 704.002 Scope of part.

The regulations governing the administration of the LHWCA as set forth in parts 702 and 703 of this subchapter govern the administration of the LHWCA extensions (see § 704.001) in nearly every respect, and are not repeated in this part 704. Such special provisions as are necessary to the proper administration of each of the extensions are set forth in this part. To the extent of any inconsistency between regulations in parts 702 and 703 of this subchapter and those in this part, the latter supersedes those in parts 702 and 703 of this subchapter.

DEFENSE BASE ACT

§ 704.101 Administration; compensation districts.

For the purpose of administration of this Act areas assigned to the compensation districts established for administration of the Longshoremen's and Harbor Workers' Compensation Act as set forth in part 702 of this subchapter shall be extended in the following manner to include:

(a) Canada, east of the 75th degree west longitude, Newfoundland, and

Greenland are assigned to District No. 1.

(b) Canada, west of the 75th degree and east of the 110th degree west longitude, is assigned to District No. 10.

(c) Canada, west of the 110th degree west longitude, and all areas in the Pacific Ocean north of the 45th degree north latitude are assigned to District No. 14.

(d) All areas west of the continents of North and South America (except coastal islands) to the 60th degree east longitude, except for Iran, are assigned to District No. 15.

(e) Mexico, Central and South America (including coastal islands); areas east of the continents of North and South America to the 60th degree east longitude, including Iran, and any other areas or locations not covered under any other district office, are assigned to District No. 2.

§ 704.102 Commutation of payments to aliens and nonresidents.

Authority to commute payments to aliens and nonnationals who are not residents of the United States and Canada, section 2(b) of the Defense Base Act, 42 U.S.C. 1652(b), though separately stated in this Act, is identical in language to section 9(g) of the Longshoremen's Act. Thus, except for the different statutory citation, the LHWCA regulation at §702.142 of this subchapter shall apply.

§ 704.103 Removal of certain minimums when computing or paying compensation.

The minimum limitation on weekly compensation for disability established by section 6 of the LHWCA, 33 U.S.C. 906, and the minimum limit on the average weekly wages on which death benefits are to be computed under section 9 of the LHWCA, 33 U.S.C. 909, shall not apply in computing compensation and death benefits under this Act; section 2(a), 42 U.S.C. 1652(a).

§ 704.151 DBA endorsement.

The following form of endorsement applicable to the standard workmen's compensation and employers' liability policy shall be used, if required by the OWCP, with the form of policy approved by the Office for use by an authorized carrier:

For attachment to Policy No. __,

The obligations of the policy include the Longshoremen's and Harbor Workers' Compensation Act, as extended by the provisions of the Defense Base Act, and all laws amendatory thereof or supplementary thereto which may be or become effective while this policy is in force.

The Company will be subject to the provisions of 33 U.S.C. 935. Insolvency or bankruptcy of the employer and/or discharge therein shall not relieve the Company from payment of compensation and other benefits lawfully due for disability or death sustained by an employee during the life of the policy.

The Company agrees to abide by all the provisions of said Acts and all lawful rules, regulations, orders, and decisions of the Office of Workmen's Compensation Programs, Department of Labor, unless and until set aside, modified, or reversed by appropriate appellate authority as provided for by said Acts.

This endorsement shall not be canceled prior to the date specified in this policy for its expiration until at least 30 days have elapsed after a notice of cancellation has been sent to the District Director and to this employer.

All terms, conditions, requirements, and obligations expressed in this policy or in any other endorsement attached thereto which are not inconsistent with or inapplicable to the provisions of this endorsement are hereby made a part of this endorsement as fully and completely as if wholly written herein.

DISTRICT OF COLUMBIA WORKMEN'S COMPENSATION ACT

§ 704.201 Administration; compensation districts.

For the purpose of administration of this Act, the District of Columbia shall be the compensation district and is designated as District No. 40.

§ 704.251 DCCA endorsement.

The following form of endorsement applicable to the standard workmen's compensation and employer's liability policy shall be used, if required by the OWCP, with the form of policy approved by the Office for use by an authorized carrier:

For attachment to Policy No. __,

The obligations of the policy include the District of Columbia Workmen's Compensation Act, and the applicable provisions of the Longshoremen's and Harbor Workers' Compensation Act, and all laws amendatory of

either of said Acts or supplementary thereto which may be or become effective while this policy is in force.

The company will be subject to the provisions of 33 U.S.C. 935. Insolvency or bankruptcy of the employer and/or discharge therein shall not relieve the company from payment of compensation and other benefits lawfully due for disability or death sustained by an employee during the life of the policy.

The company agrees to abide by all the provisions of said District of Columbia Workmen's Compensation Act and all lawful rules, regulations, orders, and decisions of the Office of Workmen's Compensation Programs, Department of Labor, unless and until set aside, modified, or reversed by appropriate appellate authority as provided for by said Act.

This endorsement shall not be canceled prior to the date specified in this policy for its expiration until at least 30 days have elapsed after a notice of cancellation has been sent to the District Director for the District of Columbia and to this employer.

All terms, conditions, requirements, and obligations expressed in this policy or in any other endorsement attached thereto which are not inconsistent with or inapplicable to the provisions of this endorsement are hereby made a part of this endorsement as fully and completely as if wholly written herein.

OUTER CONTINENTAL SHELF LANDS ACT

§ 704.301 Administration; compensation districts.

For the purpose of administration of this Act, the compensation districts established under the Longshoremen's and Harbor Workers' Compensation Act as set forth in part 702 of this subchapter shall administer this Act, and their jurisdiction for this purpose is extended, where appropriate, to include those parts of the Outer Continental Shelf adjacent to the State or States in such districts having adjacent shelf areas.

§ 704.351 OCSLA endorsement.

The following form of endorsement applicable to the standard workmen's compensation and employer's liability policy shall be used, if required by the OWCP, with the form of policy approved by the Office for use by an authorized carrier:

For attachment to Policy No. __,

The obligations of the policy include the Longshoremen's and Harbor Workers' Compensation Act, as extended by the Outer Continental Shelf Lands Act, and all the laws amendatory thereof or supplementary thereto which may be or become effective while this policy is in force.

The company will be subject to the provisions of 33 U.S.C. 935. Insolvency or bankruptcy of the employer and/or discharge therein shall not relieve the company from payment of compensation and other benefits lawfully due for disability or death sustained by an employee during the life of the policy.

The company agrees to abide by all the provisions of said laws and all the lawful rules, regulations, orders and decisions of the Office of Workmen's Compensation Programs, Department of Labor, until set aside, modified, or reversed by appropriate appellate authority as provided for by said Acts.

This endorsement shall not be canceled prior to the date specified in this policy for its expiration until at least 30 days have elapsed after a notice of cancellation has been sent to the District Director and to his employer.

All terms, conditions, requirements, and obligations expressed in this policy or in any other endorsement attached thereto which are not inconsistent with or inapplicable to the provisions of this endorsement are hereby made a part of this endorsement as fully and completely as if wholly written herein.

NONAPPROPRIATED FUND INSTRUMENTALITIES ACT

§ 704.401 Administration; compensation districts.

For the purpose of administration of this Act within the continental United States, Hawaii, and Alaska, the compensation districts established for administration of the Longshoremen's and Harbor Workers' Compensation Act as set forth in part 702 of this subchapter are established as the administrative districts under this Act. For the purpose of administration of this Act outside the continental United States, Alaska, and Hawaii, the compensation districts established for such overseas administration of the Defense Base Act as set forth in § 704.101 are established as the administrative districts under this Act.

§ 704.451 NFIA endorsement.

The following form of endorsement applicable to the standard workmen's compensation and employer's liability policy shall be used, if required by the OWCP, with the form of policy approved by the Office for use by an authorized carrier:

For attachment to Policy No. __,

The obligations of the policy include the Longshoremen's and Harbor Workers' Compensation Act, as extended by the Nonappropriated Fund Instrumentalities Act, and all of the laws amendatory thereof or supplementary thereto which may be or become effective while this policy is in force.

The company will be subject to the provisions of 33 U.S.C 935. Insolvency or bankruptcy of the employer and/or discharge therein shall not relieve the company from payment of compensation and other benefits lawfully due for disability or death sustained by an employee during the life of the policy.

The company agrees to abide by all the provisions of said Acts and all the lawful rules, regulations, orders, and decisions of the Office of Workmen's Compensation Programs, Department of Labor, unless and until set aside, modified, or reversed by appropriate appellate authority as provided for by said Acts.

This endorsement shall not be canceled prior to the date specified in this policy for its expiration until at least 30 days have elapsed after a notice of cancellation has been sent to the District Director and to the within named employer.

All terms, conditions, requirements, and obligations expressed in this policy or in any other endorsement attached thereto which are not inconsistent with or inapplicable to the provisions of this endorsement are hereby made a part of this endorsement as fully and completely as if wholly written herein.