WAIVER OF SERVICE BY REGISTERED OR CERTIFIED MAIL FOR EMPLOYERS AND/OR INSURANCE CARRIERS

Longshore and Harbor Workers' Compensation Act,
As Extended (see instructions on reverse)

Print Reset

U.S. Department of Labor
Office of Workers' Compensation Programs
www.dol.gov/owcp/dlhwc/index.htm

1. Name of Injured/Deceased Employee: _____

2. OWCP No: _____

OMB No: 1240-0053

Exp. Date: 06/01/2022

3.
- ☐ **NEW** Waiver
- ☐ **REVOKE** prior Waiver
- ☐ **CHANGE** information on prior Waiver

4. Party or Representative Agreeing to Service of Compensation Order(s) by email (check one):

- ☐ Employer
- ☐ Insurance Carrier
- ☐ Employer's Representative
- ☐ Insurance Carrier's Representative

5. I, _____, acting on behalf of _____, waive the company's statutory and/or regulatory right to be served with the compensation order(s) in this case by registered or certified mail. I instead request and consent for the company to be served with the compensation order(s) in this case by email. I agree that service of the compensation order(s) by email satisfies all service requirements imposed by 33 U.S.C. § 919(e) and 20 C.F.R. § 702.349.

I affirm that I have the authority to execute this waiver on behalf of _____. I also affirm that the information provided below is correct and accurate. If the District Director is unable to accomplish service of the compensation order(s) by email (i.e. if the email bounces back as undeliverable), I understand and agree that the compensation order(s) will be served on the company by registered or certified mail.

6. Signature: _____ Date: _____

Name: _____

Title: _____

7. Firm or Business Name (if applicable):

Name: _____

Address: Telephone Number: _____

Line1: _____ City: _____

Line2: _____ St.: _____ Zip: _____

Country: United States

8. **EMAIL ADDRESSES:** No more than two (2) email addresses can be listed per party.

_____

_____

Public Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. Public reporting burden for this collection of information is estimated to average 5 minutes per response, for locating the form on the internet, completing the information required and either mailing or uploading the form via secure portal. Use of this form is optional. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, 200 Constitution Avenue, NW, Room C-4319, Washington, D.C. 20210, and reference the OMB Control Number.

Information for Employers and Insurance Carriers (LS-801)

Under the Longshore and Harbor Worker's Compensation Act (LHWCA), parties and their representatives have a statutory and/or regulatory right to be served with compensation orders by registered or certified mail. See 33 U.S.C. § 919(e) and 20 C.F.R. § 702.349.

To expedite delivery, the Office of Worker's Compensation Programs (OWCP) will email compensation orders instead of mailing them by registered or certified mail to individuals who have submitted a "Waiver of Service by Registered or Certified Mail." (Waiver)

Waivers are case specific, and no other form/request/letter may be used to request a waiver.

Instructions for Completion of Form LS-801

Complete the waiver by completing each field on the waiver. Type or print clearly.

1) Provide the injured worker's name and OWCP case number.
2) Check whether this is a new waiver, a revocation of a prior waiver or a change to a prior waiver (e.g. an email address has changed).
3) Identify your role in the claims process as the Employer, the Employer's Representative, the Insurance Carrier or the Insurance Carrier's Representative. A separate waiver must be submitted for each party or representative electing service by email.
4) Provide your full name, title (if applicable), the name of your firm or business name, the address and the phone number.
5) Provide a valid email address to which the order should be sent. No more than two (2) email addresses can be listed per party.

This form must then be signed and dated and submitted to the OWCP/DLHWC.

a. DLHWC's Secure Electronic Access Portal (SEAPortal) may be used to electronically upload the waiver form into the case file. The SEAPortal can be accessed at the following web address:

https://seaportal.dol-esa.gov

b. If mailing the form, it should be sent to the DLHWC Central Mail Receipt site at the following address:

U.S. Department of Labor
OWCP/DLHWC
400 West Bay Street, Suite 63A, Box 28
Jacksonville, FL 32202

Warning - Your signature on the Waiver serves as a knowing and voluntary waiver of your right to receive the compensation order(s) by registered or certified mail. If you choose to receive service via email, a hard copy of the order will not be sent to you via mail.

PRIVACY ACT STATEMENT

The Privacy Act of 1974 as amended (5 U.S.C. 552a), section 919(e) of Title 33 to the US Code and 20 C.F.R. §702.349 authorizes collection of this information. The purpose of this information is to inform the District Director that the employer/insurance carrier and/or its authorized representative are waiving service of compensation orders by registered or certified mail and designating e-mail instead under the Longshore and Harbor Workers' Compensation Act (LHWCA). Completion of this form is not mandatory. Additional disclosures of this information may be to: (1) The claimant and/or his representative. (2) The employer which employed the claimant at the time of injury, or to the insurance carrier or other entity which secured the employer's compensation liability. (3) The Department of Labor's Office of Administrative Law Judges (OALJ), or other person, board or organization, which is authorized or required to render decisions with respect to the claim or other matter arising in connection with the claim. (4) Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the LHWCA to determine whether benefits are being and have been paid properly, and where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by law. (5) Failure to disclose all requested information may delay the processing of the claim, the payment of additional benefits, or may result in the payment of additional benefits.

NOTICE

If you have a substantially limiting physical or mental impairment, Federal disability non-discrimination law gives you the right to receive help from OWCP in the form of communication assistance, accommodation and modification. Please contact our office for information about the kinds of help available, such as alternate document formats.