

**AUTHORIZED INSURANCE COMPANIES UNDER THE LONGSHORE AND HARBOR
WORKERS' COMPENSATION ACT AND EXTENSIONS:**

The U.S. Department of Labor, Office of Workers' Compensation Programs, Division of Longshore and Harbor Workers' Compensation (DLHWC), renews the authority of each authorized insurance company effective July 1 of each year.

For these renewals, each insurance carrier is requested to acknowledge and agree to meet the following conditions for continuing authority:

1. comply with all statutory and regulatory obligations, including meeting timeliness for paying benefits and reporting information [Section 14(a) – (i)];
2. utilize the informal dispute resolution mechanisms in good faith by bringing only issues that are ready for resolution (i.e. all documentation is available) and sending representatives who are both prepared to and have authority to resolve issues;
3. participate and cooperate with all efforts by professional and trade associations to self-police industry compliance;
4. monitor and be held responsible for the performance in numbers 1 – 2 above of their Third Party Administrator (TPA) or other claims handlers;
5. respond to all penalty assessments in a timely manner.
6. Full compliance with the provisions of the Longshore Act 33 U.S.C. 901, et. seq.); [specifically on the performance of administrative duties and the timeliness of meeting all reporting requirements under the Regulations Governing the Administration of the Longshore Act at 20 CFR 702.147(a)]; and
7. Compliance with data reporting and proof of coverage processes. Please contact NCCI and the applicable Independent Rating Bureaus to establish and test the reporting requirements.

This statement, signed by a corporate officer, should be returned to this Office prior to July 1st (each year). Please complete all of the required information and send it to the address at the top of this letter.

Any questions may be referred to the insurance branch of this Office at (202) 693-0038.

Miranda Chiu, Director
Division of Longshore and
Harbor Workers' Compensation

Acknowledged: _____
Signature of Officer

Typed Name of Officer
Title of Officer
Company Name