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CLAIM FOR REIMBURSEMENT OF BENEFIT PAYMENTS AND CLAIMS EXPENSE UNDER THE WAR HAZARDS COMPENSATION ACT

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

Provide all information requested below. Read the instructions on the reverse of this form about submitting all required documentation. Failure to furnish the requested information will result in denial of the claim for reimbursement.

OMB Number 1240-0006
Expiration Date: 02/28/2017

IDENTIFYING INFORMATION

Employee's Name:	OWCP File No. *(if known)*

Beneficiary's Name *(if fatal case)*

Address *(employee's or beneficiary's)*

CLAIM

Claim is hereby made by *(name and address of insurance carrier or self-insured)*

.....for reimbursement of benefit payments and claims expense, as authorized by 42 USC 1704(a). Claim is made only for amounts paid in discharge of the liability of the insurance carrier or self-insured herein arising under applicable workers' compensation law, or pursuant to the terms of an applicable agreement or contract, and for reasonable and necessary claims expenses with respect thereto. This claim does not contain, nor will the insurance carrier or self-insured demand, a claim for an additional charge or loading for war-risk hazard, as defined in 42 USC 1711(b).

BENEFITS PAID AND AMOUNT CLAIMED AS CLAIMS EXPENSE

Periodic payments	$ _____	Claims Expenses	$ _____
Medical payments	$ _____	Period covered from	_____
Burial payments	$ _____	to	_____
Other	$ _____	Specify: _____	(inclusive dates)
Total of Above	$ _____		

AGREEMENT

The insurance carrier or self-insurer agrees: (1) to abide by the rules and regulations of the Office of Workers' Compensation Programs; (2) to permit examination of the insurance records and furnish other information that may be requested by OWCP; (3) to reimburse OWCP to the extent the employee recovers damages in a third party suit; and (4) disclaims and waives any right to claim or demand, from anyone, the reimbursement of which is claimed herein and allowed by OWCP.

Authorized signature for insurance carrier or self-insured	Date _____

Instructions for Form CA-278

1. Mail one copy of this form with the attached supporting documents described below to the U.S. Department of Labor, Office of Workers' Compensation Programs, 1240 East 9th Street, Room 851, Cleveland, Ohio 44199, unless otherwise instructed.

2. File a separate form for each employee.

3. Complete every item on the form.

4. Attach supporting documents (i.e., receipts or copies of checks and drafts) that show the benefits paid. In lieu of the supporting documents, a certificate may be submitted listing benefits paid that includes (1) the payee, (2) the services rendered, (3) the amount paid, (4) the date paid, (5) the check or draft number, and (6) the signature of the certifier.

5. List all expenses incurred to the date of submitting the form. Supplemental claims for reimbursement should be made on separate forms.

6. Indicate whether the benefits paid were for detention, disability, death, etc., and state the basis for paying the claim (e.g., the nature of the particular war-risk hazard).

7. Mark each receipt or other attachment with:
   (a) the case number appearing in the claim
   (b) the employee's name, and
   (c) "EXHIBIT" to case to which attributable.

8. Attach papers in support of each case, such as copies of any compensation award, any applicable contract (or sufficient excerpt), and any applicable insurance policy, marking such supporting papers as an "EXHIBIT" to the respective case.

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 this information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the date needed, and completing and reviewing the collection of information. The authority for requesting this information is 42 U.S.C. 1701 et seq. The information will be used to determine entitlement to benefits. Furnishing the requested information is voluntary, but failure to provide the requested information may result in denial of the request for reimbursement. 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, OWCP, Room S3229, 200 Constitution Avenue, NW, Washington, D.C., 20210, and reference OMB Control Number 1240-0006. DO NOT SEND THE COMPLETED FORM TO THIS ADDRESS.

Accommodation Statement

If you have a disability (a substantially limiting physical or mental impairment), please contact our office/claims examiner for information about the kinds of help available such as communication assistance (alternate formats or sign language interpretation), accommodations and modifications.