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# Claim for Compensation

## U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs

**SECTION 1** **EMPLOYEE PORTION**

a. Name of Employee — Last | First | Middle

OMB No. 1215-0103
Expires: 08/31/2005

b. Mailing Address (*Including City State, ZIP Code*)

c. OWCP File Number

d. Date of Injury
Month Day Year

e. Social Security Number

E-Mail Address *(Optional)*

f. Telephone No./FAX No.

**SECTION 2** Compensation is claimed for:

Inclusive Date Range: From / To

Intermittent?

a. ☐ Leave without pay — ☐ Yes ☐ No — *Go to Section 3*

b. ☐ Leave buy back — ☐ Yes ☐ No — *Go to Section 3, and Complete Form CA-7b*

c. ☐ Other wage loss; specify type, such as downgrade, loss of night differential, etc. Type: — ☐ Yes ☐ No — *Go to Section 3*

d. ☐ Schedule Award (*Go to Section 4)*

If intermittent, complete Form CA-7a, Time Analysis Sheet

**SECTION 3** Have you worked outside your federal job during the period(s) claimed in Section 2? (*Include salaried, self-employed, commission, volunteer, etc.)*

☐ Yes — Name and Address of Business:

Name | Address | City | State | ZIP Code

Dates Worked: | Type of Work:

☐ No *Go to section 4*

**SECTION 4** Is this the first CA-7 claim for compensation you have filed for this injury?

☐ Yes *Complete Sections 5 through 7 and a Form SF-1199A, "Direct Deposit Sign-up"*

☐ No Has there been any change in your dependents, or has your direct deposit information changed, or has there been a claim filed with U.S. Civil Service Retirement, another federal retirement or disability law, or with the Department of Veterans Affairs since your last CA-7 claim?

☐ Yes - *Complete Sections 5 through 7 or a new SF-1199A to reflect change(s)* ☐ No - *Complete Section 7*

**SECTION 5** List your dependents (*including spouse*):

| Name | Social Security # | Date of Birth | Relationship | Living with you? Yes | No |
|---|---|---|---|---|---|
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |

*For dependents not living with you, complete items a and b below.*

a. Are you making support payments for a dependent shown above? ☐ Yes ☐ No — If Yes, support payments are made to:

Name | Address | City | State | ZIP Code

b. Were support payments ordered by a court? ☐ Yes ☐ No — If Yes, attach copy of court order.

**SECTION 6** a. Was/Will there be a claim made against a 3rd party? ☐ Yes ☐ No

b. Have you ever applied for or received disability benefits from the Department of Veterans Affairs?

☐ Yes ☐ No — Claim Number | Full Address of VA Office Where Claim Filed | Nature of Disability and Monthly Payment

c. Have you applied for or received payment under any Federal Retirement or Disability law?

☐ Yes ☐ No — Claim Number | Date Annuity Began | Amount of Monthly Payment | Retirement System (CSRS, FERS, SSA, Other)

☐ CSRS ☐ FERS ☐ SSA ☐ Other

**SECTION 7** I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States. I certify that the information provided above is true and accurate to the best of my knowledge and belief.

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud, to obtain compensation as provided by the FECA, or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both. In addition, a felony conviction will result in termination of all current and future FECA benefits.

Employee's Signature _____ Date (*Mo., day, year*) _____

**Employing Agency Portion**
**For first CA-7 claim sent, complete sections 8 through 15.**
**For subsequent claims, complete sections 12 through 15 only.**

**SECTION 8** Show Pay Rate as of

Date of Injury: Base Pay

Date: _____ $ _____ per _____

Grade: _____ Step: _____

Additional Pay Type _____ $ _____ per _____

Additional Pay Type _____ $ _____ per _____

Additional Pay Type _____ $ _____ per _____

Date Employee Stopped Work:

Date: _____ $ _____ per _____

Grade: _____ Step: _____

Type _____ $ _____ per _____

Type _____ $ _____ per _____

Type _____ $ _____ per _____

Additional pay types include, but are not limited to: Night Differential (ND), Sunday Premium (SP), Holiday Premium (HP), Subsistence (SUB), Quarter (QTR), etc. (List each separately)

**SECTION 9**

a. Does employee work a fixed 40-hour per week schedule? Yes ☐ No ☐

1. If Yes, circle scheduled days: ☐ S ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ S

2. If No, show scheduled hours for the two week pay period in which work stopped. Circle the day that work stopped.

FOR EXAMPLE ONLY

| | S | M | T | W | TH | F | S |
|---|---|---|---|---|---|---|---|
| WEEK 1 From 5/14 to 5/20 | | 8 | 4 | 6 | (6) | | |
| WEEK From 5/21 to 5/27 | | 8 | | 6 | 6 | | 4 |

| | S | M | T | W | TH | F | S |
|---|---|---|---|---|---|---|---|
| WEEK 1 From _____ to _____ | | | | | | | |
| WEEK 2 From _____ to _____ | | | | | | | |

b. Did employee work in position for 11 months prior to injury? ☐ Yes ☐ No

If No, would position have afforded employment for 11 months but for the injury? ☐ Yes ☐ No

**SECTION 10** On date pay stopped, was employee enrolled in:

a. Health Benefits under the FEHBP? ☐ No ☐ Yes Code _____

b. Basic Life Insurance? ☐ No ☐ Yes

c. Optional Use Insurance? ☐ No ☐ Yes Class _____ *(D-Z only)*

d. A Retirement System? ☐ No ☐ Yes Plan _____ *(Specify CSRS, FERS, Other)*

**SECTION 11** Continuation of Pay (COP) Received (*Show inclusive dates*):

From _____ To _____

Intermittent? ☐ Yes — Complete Time Analysis Sheet, Form CA-7a ☐ No

**SECTION 12** Show pay status and inclusive dates for period(s) claimed:

| | | | Intermittent? | |
|---|---|---|---|---|
| Sick Leave | From _____ | To _____ | ☐ Yes ☐ No | If intermittent, complete Form CA-7a, Time Analysis Sheet. |
| Annual Leave | From _____ | To _____ | ☐ Yes ☐ No | |
| Leave without Pay | From _____ | To _____ | ☐ Yes ☐ No | If leave buy back, also submit completed Form CA-7b. |
| Work | From _____ | To _____ | ☐ Yes ☐ No | |

**SECTION 13** Did employee return to work? ☐ Yes ☐ No

If Yes, date _____

If returned, did employee return to the pre-date-of-injury job, with the same number of hours and the same duties?

☐ Yes ☐ No If No, explain: _____

**SECTION 14** Remarks: _____

**SECTION 15** An employing agency official who knowingly certifies to any false statement, misrepresentation, or concealment of fact, with respect to this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on this form is true to the best of my knowledge, with any exceptions noted in Section 14, Remarks, above.

Signature _____ (*Agency Official*) Title _____ Date ___/___/___

Name of Agency _____

If OWCP needs specific pay information, the person who should be contacted is:

Name _____ Title _____

Telephone No. _____ Fax No. _____ E-Mail Address _____

# INSTRUCTIONS FOR COMPLETING FORM CA-7

If the employee does not quality for continuation of pay (for 45 days), the form should be completed and filed with the OWCP as soon as pay stops. The form should also be submitted when the employee reaches maximum improvement and claims a schedule award. If the employee is receiving continuation of pay and will continue to be disabled after 45 days, the form should be filed with OWCP 5 working days prior to the end of the 45-day period.

The CA-7 also should be used to claim continuing compensation, when a previous CA-7 claim has been made.

Collection of this information is required to obtain a benefit and is authorized by 20 C.F.R.10.106.

**EMPLOYEE** (or person acting on the employee's behalf) - Complete sections 1 through 7 as directed and submit the form to the employee's supervisor.

**SUPERVISOR** (or appropriate official in the employing agency) - Complete sections 8 through 15 as directed and promptly forward the form OWCP.

**EXPLANATIONS -** Some of the items on the form which may require further clarification are explained below:

| Section Number | Explanation |
|---|---|
| 2d. Schedule Award | Schedule awards are paid for permanent impairment to a member or function of the body. |
| 5. List your dependents | Your wife or husband is a dependent if he or she is living with you. A child is a dependent if he, or she either lives with you or receives support payments from you, and he or she: 1) is under 18, or 2) is between 18 and 23 and is a full-time student, or 3) is incapable of self-support due to physical or mental disability. |
| 6a. Was/will there be a claim made against 3rd party? | A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer who gave improper instructions for the use of a chemical to which an employee is exposed, could all be considered third parties to the injury. |
| 8. Additional Pay | "Additional Pay" includes night differential, Sunday premium, holiday premium, and any other type (such as hazardous duty or "dirty work" pay) regularly received by the employee, but does not include pay for overtime. If the amount of such pay varies from pay period to pay period (as in the case of holiday premium or a rotating shift), then the total amount of such pay earned during the year immediately prior to the date of injury or the date the employee stopped work (whichever is greater) should be reported. |
| 11. Continuation of pay (COP) received | If the injury was not a traumatic injury reported on Form CA-1, this item does not apply. |
| 14. Remarks | This space is used to provide relevant information which is not present else- where on the form. |

The authority for requesting this information is 5 U.S.C. 8101 et seq. The information will be used to determine entitlement to benefits. Furnishing the requested information is required for the claimant to obtain or retain a benefit. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974, as amended (5 U.S.C. 552a). Failure to furnish the requested information may delay the process, or result in an unfavorable decision or a reduced benefit.

### Public Burden Statement

Public reporting burden forth is collection of information is estimated to average 13 minutes per response including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this estimate or any other aspect of this information collection, including suggestions for reducing this burden, please send them to the Department of Labor, Office of Workers' Compensation Programs, Room S-3229, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

**DO NOT SEND THE COMPLETED FORM TO THIS OFFICE**