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

Claim for Reimbursement of Benefit Payments and Claims Expense under the War Hazards Compensation Act

OMB Number 1240-0006
Expiration Date: 06/30/2026

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.

Injured Employee Information:

1. Employee's Last Name	2. Employee's First Name	3. Employee's Middle Initial	4. Employee's Date of Birth

5. Employee's US Address	Non-US Address (If Applicable)	6. Employee's Phone Number(s)
Line 1:	Line 1:	Home:
Line 2:	Line 2:	Cell:
City:	Country:	International:
State: Zip:	City/Region:	

DBA Information:

7. Longshore/DBA File Number	8. War Hazard File Number

Beneficiary Information (If Different from Claimant):

9. Beneficiary's Last Name	10. Beneficiary's First Name	11. Beneficiary's Middle Initial

Insurance Carrier/Self Insurer Employer Information:

12. Carrier Name	14. Carrier Address	15. Carrier Phone Number(s)
	Line 1:	Main:
	Line 2:	Ext:
13. Carrier NAIC/TAX ID Number	City:	Fax:
	State: Zip:	

Benefits Paid & Amount Claimed as Expenses:

Proof of Payment for all claimed expenses is required. Failure to submit such evidence may result in reduction in amount from OWCP. If you don't supply this information, it may result in delay in processing your claim. Please Note: If Additional Lines are needed, please include an excel spreadsheet with the needed information.

PERIODIC COMPENSATION

DATE OF SERVICE: FROM	DATE OF SERVICE: TO	AMOUNT	PROVIDER/PAYEE NAME	Receipt/Evidence Document ID

Total Claimed Amount

Comments:

LUMP SUM COMPENSATION SETTLEMENT

SETTLEMENT TYPE	DATE OF SERVICE: FROM	DATE OF SERVICE: TO	CLAIMED CONDITION	AMOUNT	PROVIDER/ PAYEE NAME	Receipt/ Evidence Document ID
☐ Past ☐ Future						
☐ Past ☐ Future						
☐ Past ☐ Future						
☐ Past ☐ Future						

Total Claimed Amount

Comments:

MEDICAL PAYMENTS

DATE OF SERVICE: FROM	DATE OF SERVICE: TO	CLAIMED CONDITION	AMOUNT	PROVIDER/PAYEE NAME	Receipt/ Evidence Document ID

Total Claimed Amount

Comments:

MEDICAL LUMP SUM COMPENSATION SETTLEMENT

SETTLEMENT TYPE	DATE OF SERVICE: FROM	DATE OF SERVICE: TO	CLAIMED CONDITION	AMOUNT	PROVIDER/ PAYEE NAME	Receipt/ Evidence Document ID
☐ Past ☐ Future						
☐ Past ☐ Future						
☐ Past ☐ Future						
☐ Past ☐ Future						

Total Claimed Amount

Comments:

ALLOCATED PAYMENTS

DATE OF SERVICE: FROM	DATE OF SERVICE: TO	CLAIMED CONDITION	AMOUNT	PROVIDER/PAYEE NAME	Receipt/ Evidence Document ID

Total Claimed Amount

Comments:

ALLOCATED LUMP SUM COMPENSATION SETTLEMENT

SETTLEMENT TYPE	DATE OF SERVICE: FROM	DATE OF SERVICE: TO	CLAIMED CONDITION	AMOUNT	PROVIDER/ PAYEE NAME	Receipt/ Evidence Document ID
☐ Past ☐ Future						
☐ Past ☐ Future						
☐ Past ☐ Future						
☐ Past ☐ Future						

Total Claimed Amount

Comments:

BURIAL PAYMENTS

DATE OF SERVICE: FROM	DATE OF SERVICE: TO	CLAIMED CONDITION	AMOUNT	PROVIDER/PAYEE NAME	Receipt/ Evidence Document ID

Total Claimed Amount

Comments:

BURIAL LUMP SUM COMPENSATION SETTLEMENT

SETTLEMENT TYPE	DATE OF SERVICE: FROM	DATE OF SERVICE: TO	CLAIMED CONDITION	AMOUNT	PROVIDER/ PAYEE NAME	Receipt/ Evidence Document ID
☐ Past ☐ Future						
☐ Past ☐ Future						
☐ Past ☐ Future						
☐ Past ☐ Future						

Total Claimed Amount

Comments:

UNALLOCATED PAYMENTS

Total Claimed Amount

Comments:

Agreement	
The carrier certifies that no additional premium or loading was charged in this claim for a war-risk hazard as defined in 42 USC 1711(b). 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.	
Carrier Attorney or Representative Name:	Carrier Attorney's Firm: Phone Number: Email Address: Street Address: City: State: Zip:
Signature of Carrier Representative, or Attorney on Behalf of Carrier	

Instructions for Form CA-278

1. Mail one copy of this form with the attached supporting documents described below to: US Department of Labor - OWCP/DFELHWC Attn: War Hazards 400 West Bay Street Room 722 Jacksonville, FL 32202
2. File a separate form for each War Hazard File Number.
3. Complete every item on the form.
4. List all expenses incurred to the date of submitting the form. Supplemental claims for reimbursement should be made on separate forms.
5. 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).
6. When completing the form's tables, where indicated you must specify to which medical condition(s) specified on the associated WH-1 each claimed reimbursement line item applies.
7. When entering lump sum compensation amounts, please check either "Past" or "Future" in the "Settlement Type" column and enter the date of the payment as listed on the LS-208 for the dates of service. Please indicate the claimed condition for the amount claimed. The "amount" is the amount of past or future compensation specified for the condition in question by the settlement agreement, not the total amount for all conditions. The provider/payee name is the party that the amount in question was paid to. If a settlement has both past and future amounts, the past amount should be listed on one line and the future amount listed on another. If there are multiple conditions, there should be separate past and/or future lines for every condition. If the settlement agreement does not provide a breakdown between past and future amounts, the entire settlement amount should be claimed as future.
8. Attach supporting documents (i.e., receipts or copies of checks and drafts) that show the benefits paid for each line item. In the form's tables, you must specify the Document ID corresponding to the documentation provided (also labeled with the Document ID) to support the claimed reimbursement line item.
9. In the Comments Section, enter the reason to why evidence is not being provided and/or explanations of requested reimbursement amounts.
10. If you have additional expenses that do not fit on this form, please attach them on separate pages.

Definitions of Common Terms

Date of Service From: This is the date of the earliest service performed, cost incurred, or payment made to or from an entity. "From" dates should be provided for each category - Periodic Compensation, Periodic Lump Sum Compensation Settlement, Medical Payments, Medical Lump Sum Compensation Settlement, Allocated Payments, Allocated Lump Sum Compensation Settlement, Burial Payments, Burial Lump Sum Compensation Settlement, and Unallocated Payments.

Date of Service To: This is the date of the most recent service performed, cost incurred, or payment made to or from an entity. "To" dates should be provided for each category - Periodic Compensation, Periodic Lump Sum Compensation Settlement, Medical Payments, Medical Lump Sum Compensation Settlement, Allocated Payments, Allocated Lump Sum Compensation Settlement, Burial Payments, Burial Lump Sum Compensation Settlement, and Unallocated Payments.

Amount: This is the requested reimbursement amount, in U.S. Dollars. Amounts should be listed for each separate invoice per category.

Provider/Payee Name: This is the name of the individual, business, or other entity that is listed on the invoice, report, settlement agreement, or other document establishing proof of payment.

Claimed Condition: Each invoice in every category that reimbursement is being sought for must be related to an accepted war-risk hazard condition. The claimed condition is the illness or injury determined to have been directly caused, aggravated, accelerated, or precipitated by a war-risk hazard. Each invoice must identify the war-risk hazard condition(s) that the service was performed in connection with.

Benefits for Employees Under the War Hazards Compensation Act (WHCA)

The WHCA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following benefits:

(1) Payment of compensation for disability, death, and burial expenses paid in cases accepted under Section 101 of the WHCA is computed in accordance with the benefit structure of the Longshore and Harbor Workers' Compensation Act, with the exception that the minimum limits of the LHWCA do not apply. Information necessary to compute compensation can be found in the Longshore Act whenever questions arise about the computation of benefits.

(2) In addition to payments made for compensation and medical bills, insurance carriers and self-insured employers are entitled to reimbursement for reasonable and necessary claims expense incurred in determining liability, including expenses for attorneys' fees, court and litigation costs, witnesses and expert testimony, examinations, and autopsies. These types of costs are known as "allocated claims expenses," and the specific expenses must be itemized and documented. An insurance carrier may also claim "unallocated claims expenses" in an amount of up to 15% of the sum of the reimbursable medical, compensation, and burial payments.

Unallocated claims expenses represent the cost incurred by the company handling the claim in its regular course of operations. These expenses cannot be specifically itemized or documented.

For additional information, review the regulations governing the administration of the WHCA 42 U.S.C. 1701 issued December 2, 1942, and amended in 1943, 1946, 1953, 1958, 1959, and 1961.

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. This collection of information is required to obtain or retain 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.

Request for Accommodations or Auxiliary Aids and Services

If you have a disability, federal law gives you the right to receive help from the OWCP in the form of communication assistance, accommodation(s) and/or modification(s) to aid you in the claims process. For example, we will provide you with copies of documents in alternate formats, communication services such as sign language interpretation, or other kinds of adjustments or changes to accommodate your disability. Please contact our office or your OWCP claims examiner to ask about this assistance.