A few tips regarding your CA-7 submissions:

1) **The fastest way to receive compensation is by submitting your CA-7 via eComp.** If you have not already created an eComp account, see enclosed brochure.

2) **To avoid delays**, always change the supervisor email address to:
HRM's email address: HRMDistrictE0079@usps.gov

3) **Ensure to request compensation for the pay period on the MONDAY AFTER EACH PAY PERIOD CLOSES:**

For example: If submitting a claim for the period ***02/04/17-02/17/17,*** then eComp the claim to us no earlier than ***02/20/17***. See below:

FEBRUARY

WEEK	QTR-2	SAT	SUN	MON	TUE	WED	THU	FRI
14	PP 03					1	2	3
15	PP	4	5	6	7	8	9	10
16	04	11	12	13	14	15	16	17
17	PP	18	19	20	21	22	23	24
18	05	25	26	27	28			

4) **You cannot submit the claim for future dates.** The pay must be verified by us after your pay records can be viewed *only after* the pay period closes.

5) If you have any questions in completing the request for compensation, please contact our office at: **(303) 853-6140.**

Filing a Form CA-7 in ECOMP

ECOMP also allows Federal employee users to file CA-7 wage loss compensation claims via the portal. CA-7 forms may be filed for cases created in ECOMP and for cases created outside ECOMP.

For cases created in ECOMP, you log in to your ECOMP account and find the CA-1 or CA-2 form for which you want to file a CA-7. Note: you can only file a CA-7 if the form has been created as a case by OWCP.

Case Created by OFEC

Employee Injured Worker

Date of Event 01/07/2019

Initiated 03/12/2019

View Get PDF File a new CA-7

Click the CA-7 link within the form's listing to begin the process.

For cases created outside of ECOMP, click the button at the top right hand side of the screen to locate an existing case and file your CA-7.

FILE CA-7 FOR CASE NOT LISTED

After you have filled out all required fields in your CA-7 and electronically submitted it to HRM, you will be notified of your form's progress every step of the way via email. You must change your supervisor's email address to: **HRMDistrictE0079@usps.gov**

Additional help and training materials for filing CA-7 claims in ECOMP can be found here:

https://www.ecomp.dol.gov/

Introducing ECOMP

Effective November 4, 2019, the Western Area of the US Postal Service will be implementing the Employee's Compensation Operations and Management Portal (ECOMP) to electronically file workers compensation forms.

ECOMP is a web-based application accessible via the Department of Labor's public Internet site. Through this portal, federal workers and their employers may:

- Electronically file workers' compensation forms;
- Track the exact status of any form or document submitted via ECOMP and
- Electronically upload and submit documents to existing DFEC case files.

For more information, please contact Health & Resource Management.

https://www.ecomp.dol.gov

Claim for Compensation

U.S. Department of Labor

Office of Workers' Compensation Programs

SECTION 1 EMPLOYEE PORTION

a. Name of Employee Last First Middle

OMB No. 1240-0046
Expires: 03-31-2021

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

You must report any and all earnings from employment (outside your federal job); include any employment for which you received a salary, wages, income, sales commissions, or payment of any kind during the period(s) claimed in Section 2. Include self-employment, odd jobs, involvement in business enterprises, as well as service with the military. Fraudulently concealing employment or failing to report income may result in forfeiture of compensation benefits and/or criminal prosecution. ***Have you worked outside your federal job for the period(s) claimed in Section 2? Refer to the Instructions which provide further clarification.***

☐ Yes Name and Address of Business:

☐ No *Go to section 4*

Name Address City State ZIP Code

Dates Worked: Type of Work:

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 If changes to dependent status, direct deposit information, or if a claim has been filed with the U.S. Civil Service Retirement, another federal retirement/disability law, or with Department of Veteran Affairs, complete Sections 5 through 7 or a new SF-1199A. If no, complete Section 7.

☐ 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). If additional space is necessary, provide same information requested below on separate page(s) and include your name/claim number at the top of the page(s).

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 noted above or on your attachment(s)? ☐ 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 criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both. In addition, a state or federal criminal conviction for FECA fraud will result in termination of all current and future FECA benefits. I understand that by signing this form, if evidence is received suggesting possible employment or earnings, I authorize OWCP to request verification of employment/earnings from the Social Security Administration.

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

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodations and/or modifications, please contact OWCP. See form instructions for Requests for Accommodations or Auxiliary Aids and Services.

Time Analysis Form

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

Employee Statement - Please carefully read instructions on reverse *before* filling out this form.

1. Name of Employee: *(Last, First, Middle)*	2. SSN	3. OWCP File Number

4. Period Covered by This Form: From: To:	5. Total Hours Claimed for LWOP: ______ for Leave BuyBack ______

6. In "Type of Leave Used" column, use codes "S" = Sick, "A" = Annual, "O" = Other. If Compensation is claimed for date, indicate "Yes" in "Compensation Claimed" column.

Date(s)	Compensation Claimed?	Number of Hours				Type of Leave Used	Reason for Leave Use/Remarks (e.g., doctor visit, therapy, etc.)
		LWOP	Worked	Hol	Leave		
Totals							

Signature of Claimant ____________________ Date Signed ____________________

7. **Agency Statement/Certification:** I certify the above is accurate, except as follows:

Signature of Agency Official ____________________ Date Signed ____________________

Form CA 7a
June 1996

Filing a CA-7a

If you file a form CA-7 claiming compensation for intermittent dates, you must also complete form CA-7a, Time Analysis, to provide details on the specific dates and hours of compensation you are claiming.

You may file a CA-7a either immediately after submitting a CA-7 by clicking the button "File a CA-7a," or by locating the CA-7 form on your Employee Dashboard and clicking the link to the right of the form.

First, information about filing a CA-7a will be displayed. Click "File a CA-7a" to proceed.

Confirmation of the case for the associated CA-7 form will be displayed. Click "Continue" to proceed.

Your supervisor's email address and the period covered by the CA-7a form will be pre-populated based on information entered for the CA-7 form. You must change the email address to: **HRMDistrictE0079@usps.gov** .

For the period covered by the CA-7a form, enter each date for which you are claiming compensation on a separate line. For each date you enter, indicate whether compensation is claimed and the number of hours of leave without pay (LWOP), work, holiday or leave you used on that date. If leave was used, indicate whether it was sick, annual or other leave using the drop down list. In the last column, also indicate the reason for your absence from work on the date you are claiming.

If you are claiming compensation for dates which cover a continuous period of LWOP or leave, you may enter a date range on one line using the "Date Range" button. For example, if your CA-7a covers a period of one month, but for one week during that month you used 40 continuous hours of LWOP, you may enter that one week period as a date range on one line of the CA-7a.

The total number of hours of LWOP, work, holiday and leave will be displayed from the information you entered in each column. You must indicate how many hours of LWOP and/or leave you are claiming. Note that the number of hours you claim may not be greater than the total for each column. If you claim compensation for leave, you will also need to complete form CA-7b, Leave Buy Back Worksheet/Certification and Election. At this time form CA-7b may not be submitted via ECOMP. You will need to contact your agency's workers' compensation coordinator for instructions on completing this form.

When you are ready to proceed, click "Continue."

Finally, confirmation of your employing organization, HRM email address, period covered by the CA-7a form and hours claimed will be displayed. To proceed, click "Sign & Submit" and agree with the displayed statement.

Confirmation will be displayed that your CA-7a has been forwarded to HRM along with the ECOMP Control Number (ECN) for your form. You may view or save a copy of the form in PDF version using the "View" and "Get PDF" buttons. When finished, click "Done" to exit.

INSTRUCTIONS for 1199A Form

Section 1 (To be completed by Payee)

A. Type or print your name, address and telephone number.
B. Type or print your name.
C. Type or print your 9-digit social security number.
D. Check the type of account you want your funds deposited into.
E. Type or print the account number you want your funds deposited into
F. (Completed by Agency)
G. Leave Blank

Sign and date the form.

Section 2 (Completed by Agency)

Section 3 (To be completed by your financial institution)

Standard Form 1199A (EG)
(Rev. August 2012)
Prescribed by Treasury Department
Treasury Dept. Cir. 1076

OMB No. 1510-0007

DIRECT DEPOSIT SIGN-UP FORM

DIRECTIONS

- To sign up for Direct Deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 *(TO BE COMPLETED BY PAYEE)*

A NAME OF PAYEE *(last, first, middle initial)*

ADDRESS *(street, route, P.O. Box, APO/FPO)*

CITY STATE ZIP CODE

TELEPHONE NUMBER
AREA CODE

B NAME OF PERSON(S) ENTITLED TO PAYMENT

C CLAIM OR PAYROLL ID NUMBER
Prefix Suffix

D TYPE OF DEPOSITOR ACCOUNT ☐ CHECKING ☐ SAVINGS

E DEPOSITOR ACCOUNT NUMBER

F TYPE OF PAYMENT *(Check only one)*

- ☐ Social Security
- ☐ Supplemental Security Income
- ☐ Railroad Retirement
- ☐ Civil Service Retirement (OPM)
- ☐ VA Compensation or Pension
- ☐ Fed. Salary/Mil. Civilian Pay
- ☐ Mil. Active ____
- ☐ Mil. Retire. ____
- ☐ Mil. Survivor ____
- ☐ Other ____ *(specify)*

G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY *(if applicable)*

TYPE	AMOUNT

PAYEE/JOINT PAYEE CERTIFICATION

I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.

SIGNATURE	DATE
SIGNATURE	DATE

JOINT ACCOUNT HOLDERS' CERTIFICATION *(optional)*

I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.

SIGNATURE	DATE
SIGNATURE	DATE

SECTION 2 *(TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)*

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS

SECTION 3 *(TO BE COMPLETED BY FINANCIAL INSTITUTION)*

NAME AND ADDRESS OF FINANCIAL INSTITUTION

ROUTING NUMBER CHECK DIGIT

DEPOSITOR ACCOUNT TITLE

FINANCIAL INSTITUTION CERTIFICATION

I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.

PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER	DATE

Financial institutions should refer to the GREEN BOOK for further instructions.

THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

BURDEN ESTIMATE STATEMENT

The estimated average burden associated with this collection of information is 10 minutes per respondent or recordkeeper, depending on individual circumstances. Comments concerning the accuracy of this burden estimate and suggestions for reducing this burden should be directed to the Financial Management Service, Records Management Branch, Room 135, 3700 East-West Highway, Hyattsville, MD 20782. THIS ADDRESS SHOULD ONLY BE USED FOR COMMENTS AND/OR SUGGESTIONS CONCERNING THE AMOUNT OF TIME SPENT TO COLLECT THIS DATA. DO NOT SEND THE COMPLETED PAPERWORK TO THE ADDRESS ABOVE FOR PROCESSING.

PRIVACY ACT NOTICE

Collection of the information in this Direct Deposit Sign-Up form is authorized by 5 U.S.C. § 552a, 31 U.S.C. § 3332(g), and Executive Order 9397 (November 22, 1943). Your social security number and the other information requested will allow the federal government to process your direct deposit. Your social security number is requested to ensure the accurate identification and retention of records pertaining to you and to distinguish you from other recipients of federal payments. This information will be disclosed to the Department of the Treasury and its fiscal and financial agents, and other federal agencies, as necessary to process your direct deposit. This information may also be disclosed to a court, congressional committee or another government agency as authorized or required to verify your receipt of federal payments. Although providing the requested information is voluntary, your direct deposit cannot be processed without it.

PLEASE READ THIS CAREFULLY

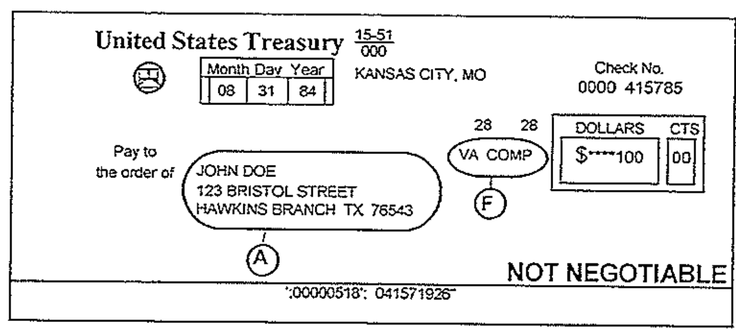
All information on this form, including the individual claim number, is required under 31 USC 3322, 31 CFR 209 and/or 210. The information is confidential and is needed to prove entitlement to payments. The information will be used to process payment data from the Federal agency to the financial institution and/or its agent. Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the Direct Deposit/Electronic Funds Transfer Program.

INFORMATION FOUND ON CHECKS

Most of the information needed to complete boxes A and F in Section 1 is printed on your government check:

Ⓐ Be sure that payee's name is written exactly as it appears on the check. Be sure current address is shown.

Ⓕ Type of payment is printed to the left of the amount.



SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS

Joint account holders should immediately advise both the Government agency and the financial institution of the death of a beneficiary. Funds deposited after the date of death or ineligibility, except for salary payments, are to be returned to the Government agency. The Government agency will then make a determination regarding survivor rights, calculate survivor benefit payments, if any, and begin payments.

CANCELLATION

The agreement represented by this authorization remains in effect until cancelled by the recipient by notice to the Federal agency or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so.

The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately advise the Federal agency if the authorization is cancelled by the financial institution. The financial institution cannot cancel the authorization by advice to the Government agency.

CHANGING RECEIVING FINANCIAL INSTITUTIONS

The payee's Direct Deposit will continue to be received by the selected financial institution until the Government agency is notified by the payee that the payee wishes to change the financial institution receiving the Direct Deposit. To effect this change, the payee will complete a new SF 1199A at the newly selected financial institution. It is recommended that the payee maintain accounts at both financial institutions until the transition is complete, i.e. after the new financial institution receives the payee's Direct Deposit payment.

FALSE STATEMENTS OR FRAUDULENT CLAIMS

Federal law provides a fine of not more than $10,000 or imprisonment for not more than five (5) years or both for presenting a false statement or making a fraudulent claim.

USPS
Leave Buy Back
Information for Employees

Definition of Leave Buy Back:

An employee who sustains a job-related injury that necessitates absence from work, may use "sick" and/or "annual" leave to avoid interruption of income while awaiting compensation from the Office of Workers' Compensation Programs (OWCP). With the approval of the USPS and OWCP, the employee may opt to "buy back" all or a portion of leave, for:

1. leave used during a period of disability caused by an occupational illness or disease and a claim for Workers' Compensation is approved, or

2. leave used during a period of disability caused by a traumatic injury and the claim for Workers' Compensation is approved. The employee may buy back leave taken after the 45 day Continuation of Pay (COP) period.

Considerations and Implications of Leave Buy Back:

1. When buying back leave, the employee will be required to pay the USPS the difference between their compensation rate (which will be two thirds or three fourths of full pay) and their actual pay. For example, if the employee's normal salary is $100/day and he/she receives $75/day (three fourths of full pay) under his/her Workers' Compensation claim, she/he will, theoretically, be obliged to pay the difference of $25 a day to the USPS to buy back the used leave. However, because compensation is not taxable or subject to other deductions, the amount payable to USPS by the employee will be less than what is illustrated in the above example.

2. Buy Back may involve significant time and effort, so the employee (if financially able) may wish to go on Leave Without Pay (LWOP) status while awaiting the approval of her/his compensation claim. Eventual compensation will include the period that employee was on LWOP.

3. Employees may buy back only the maximum number of hours of annual leave that does not exceed the carryover ceiling. Employees should verify maximum number of hours allowable for each employment category (bargaining unit, non-bargaining unit etc.).

4. Employees will not be able to make contributions to the Thrift Savings Plan (TSP) for the period of time they are on LWOP (to accomplish leave buyback). In the case of FERS employees, there will be no government contribution for the time spent on LWOP. All deductions made while an employee was in a paid leave status shall be recovered from the TSP and Retirement funds.

5. Claims for leave buy back must be made within 1 year of the date that OWCP approves the claim for compensation or 1 year from the date of return to work, whichever is later.

6. Lack of acceptable medical documentation will preclude the acceptance of buy back request. Medical documentation must cover all hours for which claim is made.

7. Employees who decide to take annual and/or sick leave instead of COP after a traumatic injury, cannot buy back the leave taken or claim OWCP compensation for the 45 day COP period.

8. Unless the period of disability exceeds 14 calendar days, there is a three day (LWOP) waiting period before compensation can be paid. The employee would not be paid compensation for the three days, but would be responsible for paying back the full amount of leave received for the three days, should he/she opt for leave buy back.

9. Buy back of leave cannot be considered after the employee has been separated from the Postal Service.

10. On the employee's leave record, leave bought back will be changed to LWOP/IOD (injury on duty). Leave is not earned during a period when an employee is in LWOP status and, therefore, the repurchase of leave will result in reduction of earned leave.

11. Tax implications:

- For cases that are processed the same tax year as the claim, the employee will see their YTD earning totals change as soon as the case is processed (change can relate to gross YTD, Fed.Tax, Medicare/SS, retirement, net, etc.)

- For cases that are processed for the prior tax year, employees will receive a W2-C for Medic and/or Social Security only. These are for employees records and they may not amend prior years taxes. Employees may claim, as a loss, the monies paid in the year of the claim providing they itemize deductions. (Further related information from IRS Revenue Ruling 79-322.)

Employees' Responsibilities in the Buy Back Process

1. Employee informs his/her supervisor of intent to apply for leave buy back. Employee is given, by the Injury Compensation Control Office (ICCO), the "Information for Employees" leaflet/pamphlet and must read it thoroughly.

2. If, having read the "Information for Employees", the employee decides to go ahead with the LBB procedure the supervisor or ICCO will provide the employee with an "estimate" of the amount of reimbursement that the OWCP will make toward the buy back of leave, as well as the amount that the employee will need to pay the agency in order to have his/her leave restored.

3. If the employee decides to continue with the leave buy back process (after receipt of estimate); this will be noted on form CA-7b Section IV which will be given to the employee by the employer.

4. Employees must make certain that their relevant medical information is secured from their medical practitioner and submitted.

Employer's Responsibilities in the Buy Back Process

1. The employer completes the relevant forms utilizing information from the local finance office. This process could be accelerated by the employee making certain that related medical documentation is quickly forthcoming. The ICCO verifies period of time claimed against Agency leave records and injury time supported by the physician.

2. Forms will then be forwarded to the Minneapolis ASC to process the buy back. The ASC will send complete and accurate forms to the relevant OWCP. Forms that are not acceptable to the ASC will be sent back to the ICCO for corrections and/or additional information.

3. OWCP will inform the employee of their decision, through the use of Form CA-1208, stating the compensation amount to repurchase leave (if Agency estimate is within 10%, OWCP will make payment to the USPS. The form also restates the employee's obligation to pay any balance due for the repurchase directly to the USPS.

Forms Used in the Buy Back Process

OWCP Form CA-7 " Claim for Compensation On Account of Traumatic Injury or Occupational Disease". This form identifies period for which compensation is claimed and provides information about the claimant and his/her dependents, and specific information related to wage loss and benefits previously received.

OWCP Form CA-7b "LBB Worksheet/Certification and Election Form". This form is used to calculate entitlement and includes information related to:

Weekly base pay rates at Date of Injury, Date Stopped Work and Date of Recurrence. Information related to weekly pay rate and "additions to base pay must also be included (e.g. night differential, Sunday premium, subsistence/quarters, etc.).

OWCP Form CA-7a "Time Analysis Form". This form is to be completed where more that one continuous period of leave or LWOP is claimed or where leave or LWOP used has been intermittent.

OWCP Form Letter CA-1208 which provides notification of approval of buy back claim and advice of payment made.

PRIVACY ACT NOTICE — Office of Workers' Compensation Program Forms

This notice contains a privacy statement applicable to **U.S. Department of Labor, Employment Standards Administration, Office of Workers' Compensation Program (OWCP)** forms that are used by the U.S. Postal Service® (USPS®). This notice must be given to an individual completing any one of the forms listed below in compliance with the provisions of the Privacy Act of 1974.

This notice includes the principal purpose(s) for which the information is being collected, the laws that allow the Postal Service™ to collect the information, any effects upon an individual for not providing the information, and the circumstances (Routine Uses) in which the information may be disclosed.

CA-1	Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation
CA-2	Notice of Occupational Disease and Claim for Compensation
CA-2a	Notice of Recurrence
CA-5	Claim for Compensation by Widow, Widower, and/or Children
CA-5b	Claim for Compensation by Parents, Brothers, Sister, Grandparents, or Grandchildren
CA-7	Claim for Compensation
CA-7a	Time Analysis Form
CA-7b	Leave Buy Back (LBB) Worksheet/Certification and Election
CA-12	Claim for Continuance of Compensation under the Federal Employees' Compensation Act
CA-16	Authorization for Examination and/or Treatment
CA-17	Duty Status Report
CA-20	Attending Physician's Report
CA-1108	Short Form Statement of Recovery (Third-Party Claim)
CA-1122	Long Form Statement of Recovery (Third-Party Claim)
OWCP-915	Claim for Medical Reimbursement
OWCP-957	Medical Travel Refund Request
OWCP-1500	Health Insurance Claim Form

Privacy Act Statement: Your information will be used to process your claim under the Federal Employees' Compensation Act. Collection is authorized by 39 U.S.C. 401, 410, 1001, and 1005.

Providing this information is voluntary, but if not provided, we may be unable to process your request. We may disclose your information as follows: in relevant legal proceedings; to law enforcement when the USPS or requesting agency becomes aware of a violation of law; to a congressional office at your request; to entities or individuals under contract with USPS; to entities authorized to perform audits; to labor organizations as required by law; to federal, state, local or foreign government agencies regarding personnel matters; to the Equal Employment Opportunity Commission; and to the Merit Systems Protection Board or Office of Special Counsel.