# Filing for Compensation Benefits

# Filing for Compensation Benefits

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# Form CA-7

- Form CA-7 is used to claim compensation for wage loss while in a leave without pay (LWOP) status due to disability or absence to obtain medical treatment (after continuation of pay (COP) period for traumatic injury cases).

- Form CA-7 is also used to claim leave buy back, schedule award or lost pay elements (ie, night differential, Sunday premium, holiday pay, etc).

- Form CA-7 should be submitted by an injured worker (IW) every two weeks while disabled and in a LWOP status, unless the IW has been placed on the periodic roll.

- For traumatic injury cases, Form CA-7 should be completed before the end of the COP period, if disability will continue.

# Form CA-7  Adjudication

- Employing agency (EA) should submit completed Form CA-7 to the Office of Workers' Compensation Programs (OWCP) within five work days of receipt from IW.

- OWCP tries to review wage loss claims within five days of receipt, and take action to develop or pay within 14 days of receipt from EA.

# Benefit Types – Wage Loss

- Compensation for wage loss is paid when the IW loses wages due to:

  - Temporary total disability = completely off work
  - Partial disability = working reduced hours and/or working at reduced pay (e.g. loss of premium pay due to shift change)
  - Medical treatment = intermittent wage loss for doctor's appointments, therapy, tests, etc.

- Payments are calculated based on the IW's payrate for compensation purposes and dependency status.

# Benefit Types– Leave Buy Back

- When an IW elects to use accrued sick or annual leave during a period of disability, he or she may later, with the concurrence of EA, claim compensation for the period of disability and "buy back" the leave used (20 C.F.R. § 10.425).

- The FECA does not govern whether a claimant may or may not buy back leave from an EA, and any decision by EA to disallow leave buy back is not a decision of OWCP over which the Employees' Compensation Appeals Board may exercise jurisdiction.

# Leave Buy Back

Leave Buy Back (LBB):

- EA and IW must complete Form CA-7b. Form CA-7b provides an estimate of the cost to the IW to reinstate the used leave.
- OWCP makes the determination on whether or not the medical evidence is sufficient to support all of the hours claimed.
- If there is medical evidence for all hours claimed but EA's estimate of FECA entitlement is off by more than 10 percent, then the claims examiner will advise IW and ask if he/she wishes to continue with the leave repurchase.
- OWCP makes payment directly to EA (address provided on Form CA-7b).

# Benefit Types – Schedule Award

5 U.S.C. 8107 provides compensation for the permanent loss or loss of use of specified members, functions, and organs of the body.

- Payment is made for a specified number of days or weeks according to the severity of the impairment.
- A schedule award (SA) may not be paid concurrently with loss of wage compensation related to the same specified members, functions, and organs of the body; but may be paid concurrently with OPM benefits.
- The law does not allow for payment of an SA award for impairment to the back, heart or brain. However, a back injury may result in impairment to an appendage, which would be eligible for an SA.

# Schedule Award

Required Medical Evidence:

• The medical evidence must show that the specified member, organ or function has reached a permanent and fixed state, and indicates the date on which this occurred ("date of maximum medical improvement").

• Describe the impairment in sufficient detail so OWCP can visualize the character and degree of impairment.

• Provide a percentage evaluation of the impairment in terms of the affected member or function, not the body as a whole (except for impairment to the lungs) according to the 6th edition of the AMA Guide.

# Schedule Members

| Anatomical Member | Maximum Number of Weeks |
|---|---|
| Arm | 312 |
| Leg | 288 |
| Hand | 244 |
| Foot | 205 |
| Eye | 160 |
| Thumb | 75 |
| First Finger | 46 |
| Great Toe | 38 |
| Second Finger | 30 |
| Third Finger | 25 |
| Toe (other than great) | 16 |
| Fourth Finger | 15 |

# Schedule Members

| Anatomical Member | Maximum Number of Weeks |
|---|---|
| Complete Hearing Loss (one ear) | 52 |
| Complete Hearing Loss (both ears) | 200 |
| Breast (one) | 52 |
| Kidney (one) | 156 |
| Larynx | 160 |
| Lung (one) | 156 |
| Penis | 205 |
| Testicle (one) | 52 |
| Tongue | 160 |
| Ovary (one) | 52 |
| Uterus/ cervix | 205 |
| Vulva/ vagina | 205 |
| Skin | 205 |

# Schedule Award – Added Member

New Regulations: Skin

Effective August 29, 2011 (pursuant to the authority provided by 5 U.S.C. 8107(c)(22)), the Secretary of the U.S. Department of Labor added a schedule award for the skin which may be paid for injuries on or after September 11, 2001.

# Schedule Award

Lump Sum Payments:

- A lump-sum payment of schedule award benefits may be made where the evidence shows that such a payment would be in IW's best interest. There is no absolute right to a lump-sum payment of schedule award benefits.
- Every case must be considered on its individual merits.
- Generally a lump sum will not be considered in IW's best interest where the compensation payments are relied upon as a substitute for lost wages.

# Filing for Compensation Benefits

## Completing Form CA-7

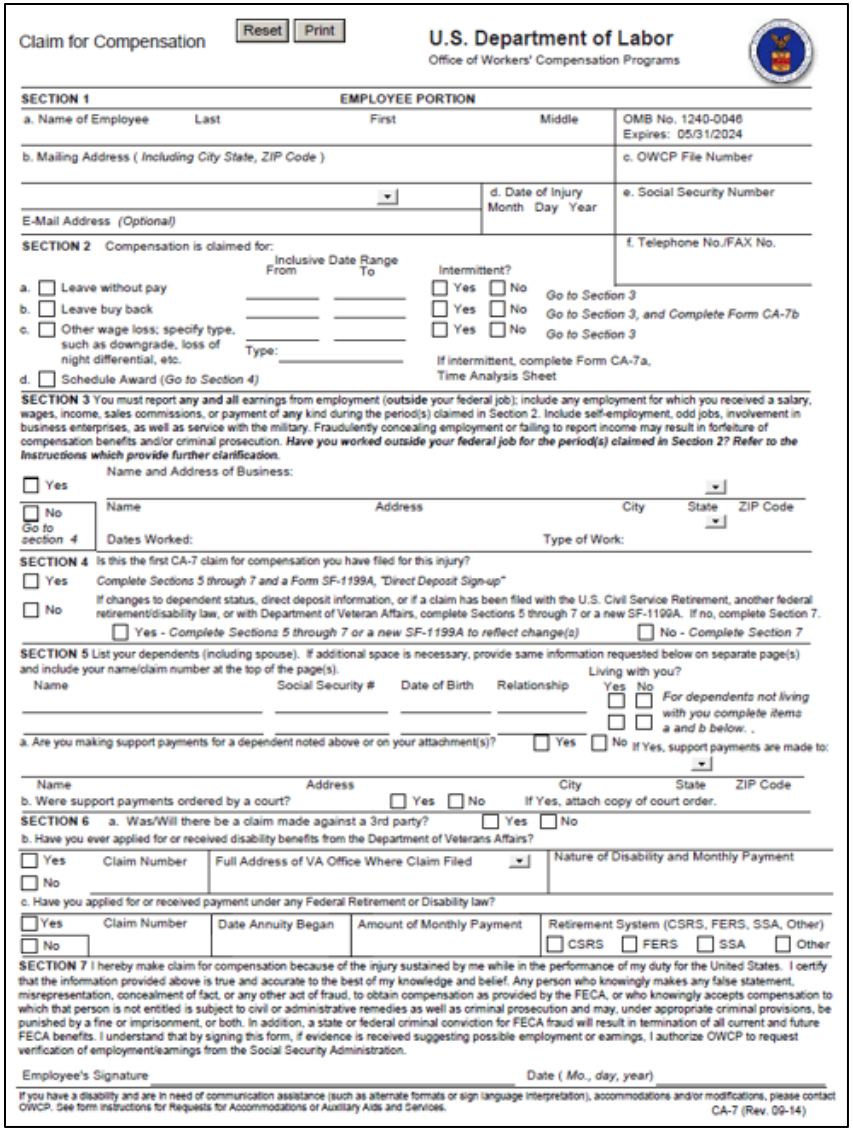
# Form CA-7 – Agency's Responsibilities

- Ensure the correctness of information supplied by IW.
- If IW does NOT have a fixed schedule, ensure the prior year earnings are submitted for date of injury (DOI) and date IW stopped work, including premium pay.
- Make certain the second page of the CA-7 form is completed accurately. Provide the pay rate for DOI and date IW stopped work.
- If wage loss is intermittent, complete Form CA-7a.
- Submit dates that COP was paid. If COP was paid intermittently, complete Form CA-7a for the COP dates.
- Verify health insurance and life insurance codes, and submit a statement with the last date withheld by EA.

# Form CA-7 – Agency's Responsibilities

- Supply the name, email address, and telephone number of the contact who has knowledge of IW's pay.
- Agency should instruct IW to file Form CA-7 in ECOMP once they have received COP for at least 30 days ***and*** it appears disability will exceed 45 days, or as soon as pay stops.
- Accuracy of pay information is critical.
- Form CA-7 must be forwarded to OWCP within five work days of IW's signature date. Ensure timeliness of submission (think of impact on IW).
- Form CA-7 should be filed at two-week intervals if the IW continues to be disabled beyond the period claimed on Form CA-7 unless otherwise notified by OWCP.

# Form CA-7 – Page One



Claim for Compensation [Reset] [Print]

**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: 05/31/2024

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: Name — Address — City — State — ZIP Code

☐ No *Go to section 4*

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?

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

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

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

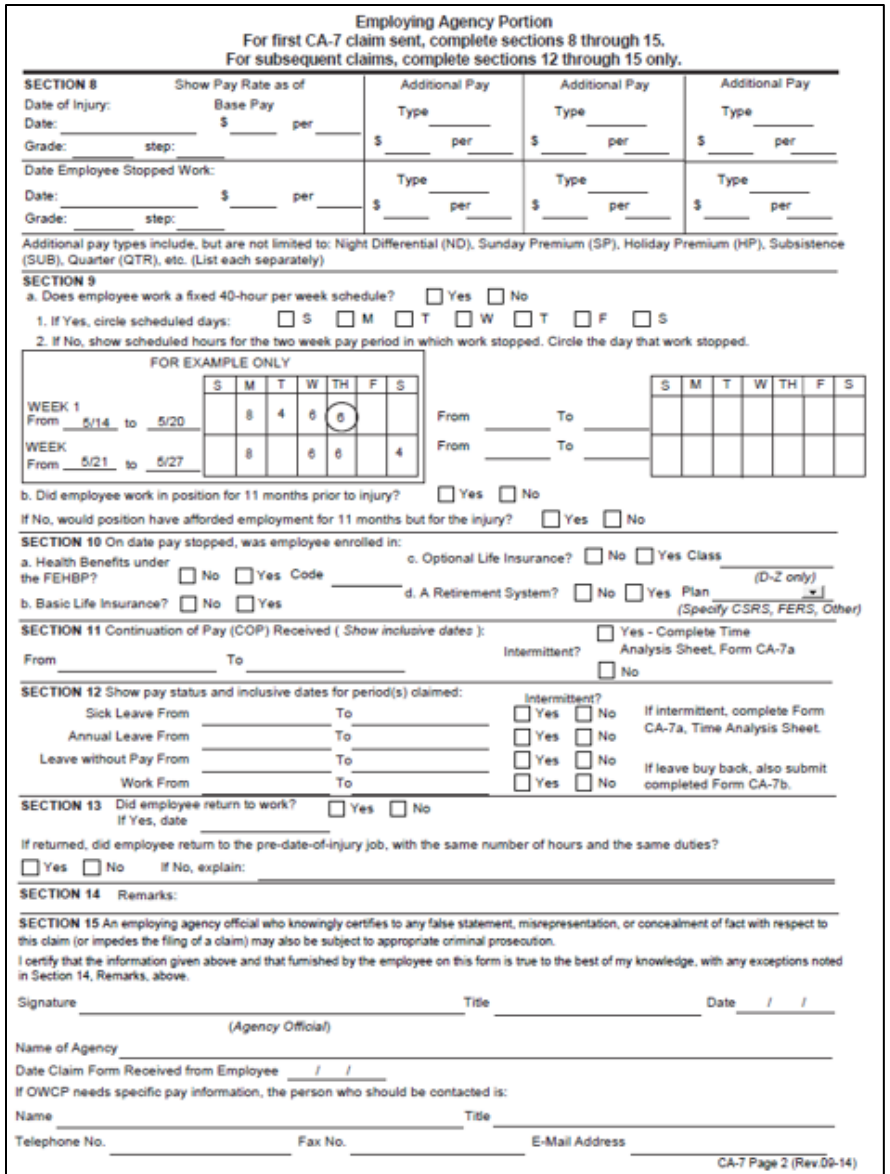
**SECTION 7** I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States. I certify that the information provided above is true and accurate to the best of my knowledge and belief. Any person who knowingly makes any false statement,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

CA-7 (Rev. 09-14)

# Form CA-7 – Page Two



**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: _____

Date Employee Stopped Work:
Date: _____ $ _____ per _____
Grade: _____ step: _____

| Additional Pay | Additional Pay | Additional Pay |
|---|---|---|
| Type _____ | Type _____ | Type _____ |
| $ _____ per _____ | $ _____ per _____ | $ _____ per _____ |
| Type _____ | Type _____ | Type _____ |
| $ _____ per _____ | $ _____ per _____ | $ _____ 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 ☐ T ☐ 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 |
|---|---|---|---|---|---|---|---|
| From _____ To _____ | | | | | | | |
| 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 Life 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 (or impedes the filing of a claim) may also be subject to appropriate 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 _____ Title _____ Date ___/___/___
*(Agency Official)*
Name of Agency _____
Date Claim Form Received from Employee ___/___/___
If OWCP needs specific pay information, the person who should be contacted is:
Name _____ Title _____
Telephone No. _____ Fax No. _____ E-Mail Address _____

CA-7 Page 2 (Rev.09-14)

# Form CA-7

**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<br>Date: _____ $ _____ per _____<br>Grade: _____ step: _____ | Additional Pay<br>Type _____<br>$ _____ per _____ | Additional Pay<br>Type _____<br>$ _____ per _____ | Additional Pay<br>Type _____<br>$ _____ per _____ |
| Date Employee Stopped Work:<br>Date: _____ $ _____ per _____<br>Grade: _____ step: _____ | Type _____<br>$ _____ per _____ | Type _____<br>$ _____ per _____ | Type _____<br>$ _____ 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) | | | |

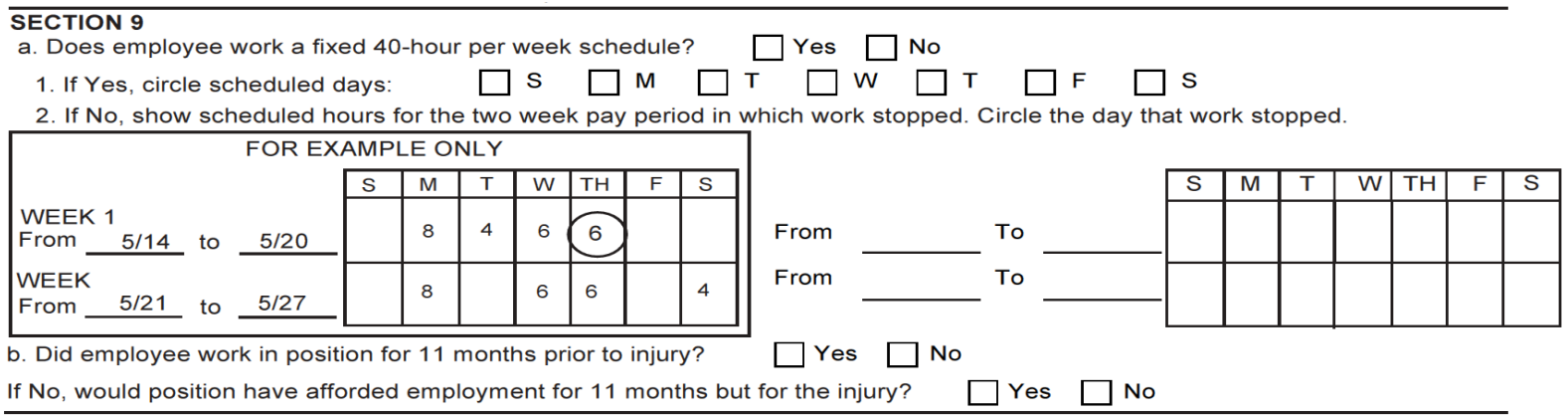
**Section 8**

- Please provide the date of injury, the claimant's grade and step on that date, and the claimant's base pay on that date. Please also provide the date the claimant stopped work, his/her grade and step on that date, and his/her base pay on that date. Base pay can be provided annually, weekly, or hourly but make sure you mark down which you are providing.

- Please report the type of additional pay the claimant was entitled to on the date of injury and the date he/she stopped work. Additional pay may include night differential, Sunday premium pay, holiday pay, etc.

- When reporting pay and/or pay elements, please specify if the reported amount is annually, weekly, or hourly.

# Form CA-7



**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 ☐ T ☐ 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 |
|---|---|---|---|---|---|---|---|
| From ____ To ____ | | | | | | | |
| 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 9**

- Part a: Accurately indicate if the claimant worked a fixed 40 hour per week schedule on the date he/she stopped work. If yes, provide his/her scheduled days of the week. If no, show the scheduled days and hours he/she worked in the two week period in which he/she stopped work and specify the day he/she stopped work.

- Part b: Indicate whether the claimant had worked in the position for at least 11 months prior to the date he/she stopped work. If no, please answer yes or no as to whether EA would have afforded employment for 11 months but for the injury.

* If the claimant did not work a **fixed full time** schedule on the date he/she stopped work, provide his/her total year prior annual earnings. If he/she did not work at least 11 months in the position prior to the work stop date, provide the total year prior earnings of a similar employee who worked the greatest number of hours during that period.

# Form CA-7

**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 Life Insurance? ☐ No ☐ Yes Class _____ *(D-Z only)*

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

**Section 10**

- Indicate whether the claimant was enrolled in health benefits at the time he/she stopped work. If yes, provide the specific health benefit enrollment code.
- Indicate whether the claimant was enrolled in basic life insurance at the time he/she stopped work.
- Indicate whether the claimant was enrolled in optional life insurance at the time he/she stopped work. If yes, provide the specific optional life insurance class.
- Also indicate whether the claimant was enrolled in a retirement system at the time he/she stopped work. If yes, provide the specific retirement plan.
- If the claimant was enrolled in federal dental and/or vision insurance, indicate in Section 14.
- If the claimant was enrolled in health benefits or life insurance, please also submit a statement with the last date withheld by EA.

# Form CA-7

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

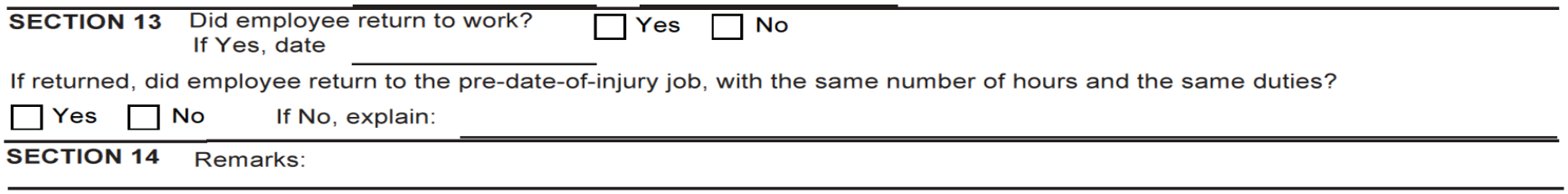
From _____ To _____

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

**Section 11**

- Please provide the dates that the employee received COP for this injury (if applicable) and a Time Analysis if COP was used intermittently.

# Form CA-7


**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 13**

- Please answer yes or no as to whether the claimant returned to work. If yes, the date the claimant returned to work should be provided.
- Additionally, please answer yes or no as to whether the claimant returned to the pre-date-of-injury job, with the same number of hours and the same duties. If no, please explain what the claimant's current status is. For example, did the claimant return to work full-time/limited duty, part-time/limited duty (if part-time please note the number of hours), etc?

**Section 14**

Please provide any remarks in this section. For example: number of hours LWOP-certified (i.e., 80 hours LWOP), claimant scheduled to undergo surgery on this date, year prior annual salary information, if applicable, or any other remarks pertaining to the claim for compensation.

# Form CA-7

**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 _____ Title _____ Date ___/___/___

(*Agency Official*)

Name of Agency _____

Date Claim Form Received from Employee ___/___/___

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

Name _____ Title _____

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

**Section 15**

- Provide your name and title.
- Provide the date EA received the form from the employee.
- Provide the name, email address, and telephone number of the person who should be contacted if OWCP needs specific pay information.

# Filing for Compensation Benefits

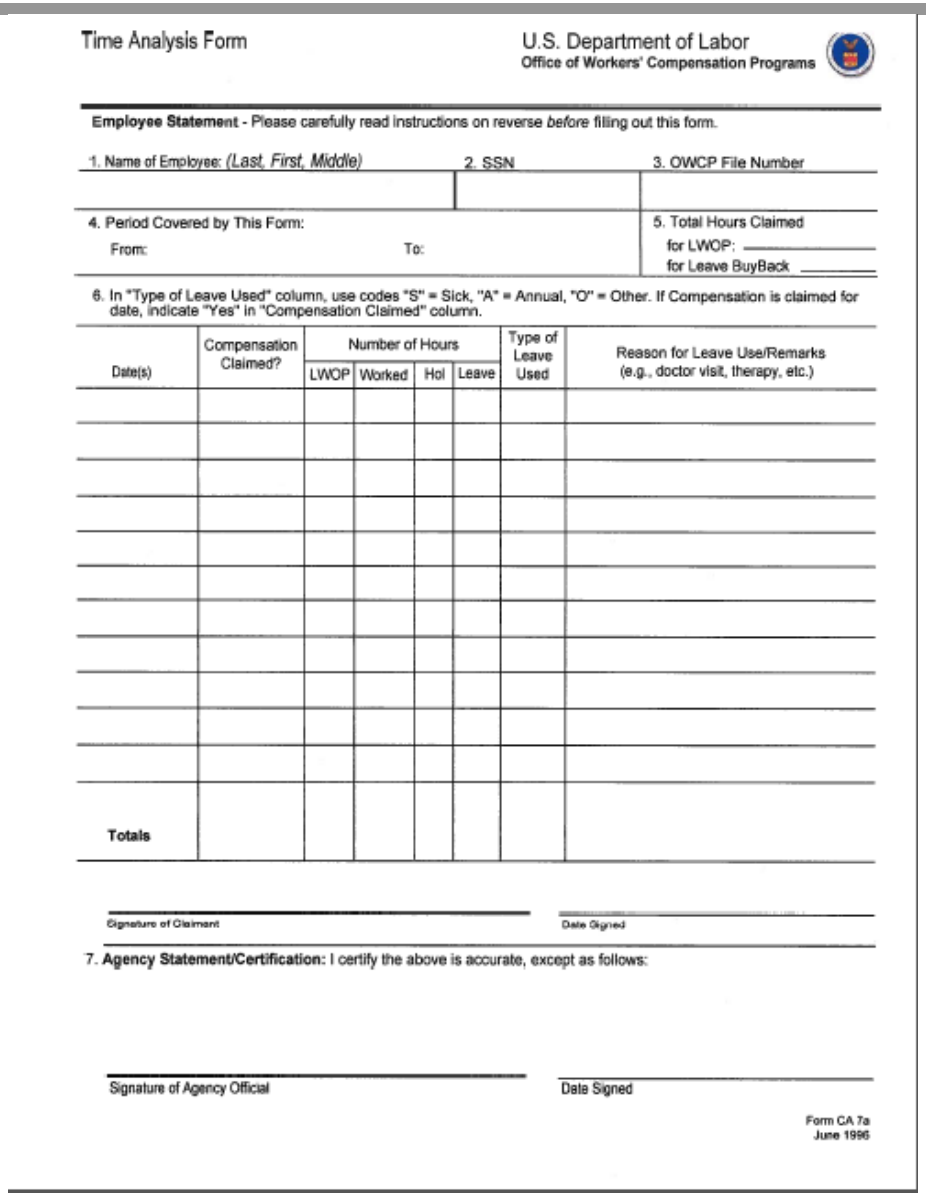
## Form CA-7a Review

# Form CA-7a

CA-7a = Time Analysis form:

- Supplements Form CA-7 when disability/time loss from work is intermittent or for partial days.
- Allows for individual hours to be claimed on specific days in a claimed period, rather than full days.
- Is used to document and claim time lost due to OWCP related medical appointments and treatments.
  - Compensation payments for medical appointments must be supported by attendance records or medical evidence in file.

# Form CA-7a



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 | | |
| | | | | | | | |
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| | | | | | | | |
| **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 for Compensation Benefits

## Form CA-7b Review

# Form CA-7b

CA-7b = Leave Buy Back (LBB) Worksheet:

- Form CA-7b is an LBB worksheet which is completed by EA and it provides IW with an estimate of the cost to restore any sick/annual leave used as a result of the work injury.
- Section III of Form CA-7b provides IW with an election to pursue the LBB based on EA's estimate.

# Form CA-7b – Page One

Leave Buy Back (LBB) Worksheet/
Certification and Election

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

**Employee Statement** - Please carefully read instructions on pages 3 and 4 *before* filling out this form.

| A. Name of Employee: *(Last, First, Middle)* | B. OWCP File Number: |
|---|---|
| C. Social Security Number: | |

D. Period for Which Compensation is Claimed to Repurchase Leave

From: ____ / ____ / ____ To: ____ / ____ / ____

**I. Agency Estimate of FECA Entitlement:**

**A. Weekly Base Payrate** *(excluding overtime)*

- Date of Injury ____ / ____ / ____ $ _____
- Date Stopped Work ____ / ____ / ____ $ _____
- Date of Recurrence ____ / ____ / ____ $ _____

Enter the greatest amount and the effective date of that amount on line 1. 1. _____

____ / ____ / ____
*(effective date)*

**B. Additions to Base Pay:**
If employee works a regular schedule, state the amount earned weekly. If irregular schedule, state amount earned 1 year prior to date entered on line 1 ÷ by 52.

- Night Differential 2. _____
- Sunday Premium 3. _____
- Subsistence/Quarters 4. _____
- Other *(Specify)* 5. _____

**C. Total Weekly Payrate** *(Add lines 1 through 5)* 6. _____

**D. Compensation Rate** *(Circle either 2/3 or 3/4)* 7. 2/3 3/4

**E. Total Hours Claimed on CA-7a** 8. _____

**F. Total Hours Worked per Week** 9. _____

**G. Formula** ***(for FECA Entitlement)***

$ _____ (Weekly Payrate See Line 6) X _____ (Compensation Rate See Line 7) X _____ (Hours See Line 8) ÷ _____ (Hours Wkd/Wk See Line 9) = 10. $ _____

Page 1

Form CA 7b
June 1996

# Form CA-7b – Page Two

**II. Agency Certification:**

H. **Total Amount Due Agency to Repurchase Leave** 11. $_____

I. **Estimate of FECA Entitlement** *(See Line 10)* 12. $_____

J. **Balance Due Agency from Employee** *(Line H minus Line I)* 13. $_____

I hereby certify that the above is consistent with agency payroll records.

The employing agency agrees to allow the employee to repurchase his/her leave. Leave records will be, or have been, changed from "Leave with Pay" to "Leave without Pay" for the period shown on the leave analysis.

I further certify that if this claim is signed by the employee, the employee has made arrangements to pay the agency the balance between the total amount the agency requires to recredit leave and the amount of the FECA entitlement.

_____ _____

(Signature of Agency Official) (Title/Position)

Phone No _____ Date Signed: _____

Employing Agency Address for Check: _____

_____

_____

**III. Employee Claim:**

_____ K. I hereby elect not to repurchase the leave used at this time.

_____ L. I hereby elect FECA compensation to repurchase leave used for medical care or disability resulting from my Job-related injury or condition.

I understand that I am responsible for paying my agency the difference between the FECA entitlement and the amount my agency requires to restore my leave, and have done or made arrangements for this.

I understand that if my actual entitlement to FECA compensation is within 10% of the amount estimated above, OWCP will process the leave buy back. If the payrate used in the worksheet above is within 10% of the payrate determined by FECA, and less than the full period claimed is approved, OWCP will process payment for the approved period.

_____ _____

(Signature of Claimant) (Date Signed)

Page 2

# Filing for Compensation Benefits

## Calculating Compensation

# Calculating Compensation – Pay Rate

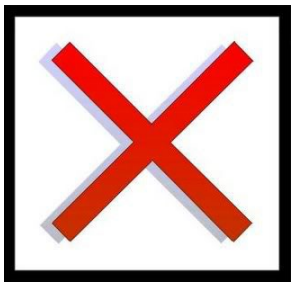
- Pay rate for compensation is based upon:
  - Date of injury;
  - Date that disability began; or
  - Date of recurrence, when disability recurs at least 6 months after return to regular full time employment

# Calculating Compensation – Elements of Pay

- The following elements of pay are <u>included</u> in computing an employee's pay rate:
  - Employee's full salary or full cash wage;
  - Night or shift differential;
  - Extra compensation/premium pay for Sunday or holiday work;
  - Administratively uncontrolled overtime;
  - Extra pay received by immigration and customs inspectors;
  - Availability pay for criminal investigators;
  - Heavy duty pay for rural carriers;
  - Quarters allowance for overseas personnel;
  - Dirty work pay;
  - Hazard pay;
  - Locality pay and COLA; and
  - Remote worksite allowance.

# Calculating Compensation – Elements of Pay

- The following elements of pay are excluded in computing an employee's pay rate:
  - Overtime pay;
  - Locality/COLA pay for an employee outside of the US;
  - Bonus or premium pay for extraordinary service;
  - Per diem while in travel status;
  - Allowance for use of personal vehicle;
  - Unemployment compensation;
  - Earnings as an activated reservist or National Guard member when the activation is not as a result of a presidential call; and
  - Earnings as a reservist or National Guard member when the membership is not a condition of the employee's civilian employment with the Guard or Reserve.



# Calculating Compensation – Compensation Rate

- The basic compensation rate is 66 2/3%, which is increased to 75% if there is at least one eligible dependent:
  - A husband or wife who lives with the employee.
  - An unmarried child (including an adopted child or stepchild) who lives with the employee, is under 18 years of age, and the employee makes regular direct payments for his or her support.
  - An unmarried child who is 18 years of age or older, but who cannot support himself or herself because of mental or physical disability, and the employee makes regular direct payments for his or her support.
  - An unmarried child (who is at least 18 years of age, but under 23 years of age) who is a full-time student, and has not completed four years of school beyond the high school level.
  - A parent who is totally dependent upon the employee for support.
  - A spouse or dependent child who does not live with the employee, but to whom you make regular direct payments for his or her support, either as ordered by a Court or through informal arrangement.

# Calculating Compensation – Minimum/Maximum

**Minimum**

Established by the 1966 FECA amendments as 75% of the lowest pay for a GS-02 employee.

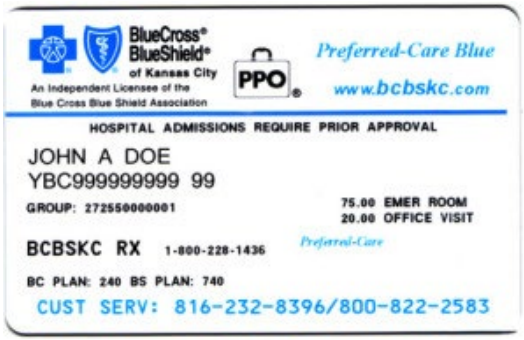
**Maximum**

Established by the 1966 FECA amendments as 75% of the monthly salary of a GS-15, Step 10 employee.

# Calculating Compensation – Deductions

Health Benefits:

- Effective September 2010, OWCP deducts Health Benefits (HB) and Optional Life Insurance (OLI) premiums from the first day of wage loss if the employee was enrolled when disability began.
- HB Enrollments transferred when:
  - Enrollment package requested by OWCP - after 90 days in LWOP
  - If employee is terminated from EA rolls – EA should notify OWCP of the termination and request transfer out of HBI to OWCP rather than terminating HBI benefits.
- How to transfer:
  - Letter to OWCP with copies of all SF-2809s
  - SF-2810 no longer required



# Calculating Compensation – Deductions

**Life Insurance/FEDVIP Insurance:**

- If the employee is in LWOP, life insurance continues if he/she was enrolled while employed.
- If terminated from employment by his/her EA, the employee must have been enrolled for 5 years or at 1st available opportunity.
- Deductions for FEDVIP are initiated by OPM contacting National Office for cases on the periodic roll.

**Miscellaneous Deductions:**

- Deductions for recovery of overpayments to the claimant
- Child support when a court order is submitted directing OWCP to deduct
- Social security offsets
- Repayment of dual benefits to OPM

# Calculating Compensation – CPI Increases

The 1966 FECA Amendments provided for increases in compensation benefits based upon the Consumer Price Index (CPI). Under Section 5 U.S.C. 8146a, increases are granted where the disability (i.e., compensable disability or the date when an IW stopped work on account of the injury) occurred more than one year before the effective date of the increase. The CPI increases are effective March 1 of each year.

# Calculating Compensation - Payment

Wage Loss Payments:

- Daily Roll: Used for payment of short periods of disability or intermittent hours of wage loss.

- Periodic Roll: Used for payment of extended periods of disability. Payments issued once every four weeks, following a payment cycle.

# Calculating Compensation – Waiting Days

- Under Section 5 U.S.C. 8117, the waiting days are the first three calendar days of injury-related disability following the termination of any continuation of pay (COP), or any sick or annual leave used, if IW is in a non-pay status for all or part of those days.
- This provision applies regardless of whether the three days are regularly scheduled non-work days (e.g., Saturday and Sunday) or holidays.
- Non-work days occurring prior to or during any period of COP or leave use should not be considered as waiting days.
- If the disability exceeds 14 days from the time compensation begins, no waiting period is required.

# Form CA-7 TASK

Review the 15 sections of the completed Form CA-7 (front and back) on the following four slides, and find the 11 errors or missing information.

Claim for Compensation

Reset Print

# U.S. Department of Labor

Office of Workers' Compensation Programs

## SECTION 1 EMPLOYEE PORTION

| a. Name of Employee | Last | First | Middle |
|---|---|---|---|
| | **Smith** | **John** | **M** |

OMB No. 1240-0046
Expires: 10-31-2014

b. Mailing Address ( *Including City State, ZIP Code* )
**123 Tree Lane, Anytown, OH 44125**

c. OWCP File Number

E-Mail Address *(Optional)*

d. Date of Injury
Month Day Year
**01/01/2012**

e. Social Security Number
**123-45-6788**

f. Telephone No./FAX No.
**(123) 456-7890**

## SECTION 2 Compensation is claimed for:

| | | Inclusive Date Range From | To | Intermittent? | |
|---|---|---|---|---|---|
| a. | [x] 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 **all** earnings from employment ( **outside** your federal job); include any employment for which you received a salary, wages, income, sales commissions, piecework, or payment of **any** kind during the period(s) claimed in Section 2. Include self-employment, involvement in business enterprises, as well as service with the military forces. Fraudulent concealment of employment or failure 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 ?***

[ ] Yes

[ ] No *Go to section 4*

Name and Address of Business:
**N/A**

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?

[x] 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?

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

| Name | Social Security # | Date of Birth | Relationship | Living with you? Yes | Living with you? No |
|---|---|---|---|---|---|
| **Mary Smith** | **123-45-6788** | **01/01/1929** | **Wife** | ☒ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |

*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?

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

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

| | Claim Number | Date Annuity Began | Amount of Monthly Payment | Retirement System (CSRS, FERS, SSA, Other) |
|---|---|---|---|---|
| ☒ Yes ☐ No | | | | ☐ 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 | Additional Pay | Additional Pay | Additional Pay |
|---|---|---|---|
| Date of Injury: Date: **01/01/2012** Base Pay $ _____ per _____ Grade: **7** step: **1** | Type _____ $ _____ per _____ | Type _____ $ _____ per _____ | 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 ☐ T ☐ 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 |
|---|---|---|---|---|---|---|---|
| From _____ To _____ | | | | | | | |
| 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 **401**

b. Basic Life Insurance? ☐ No ☒ Yes

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

d. A Retirement System? ☐ No ☒ Yes Plan **FERS** *(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 |
| Annual Leave From | | To | ☐ Yes | ☐ No |
| Leave without Pay From | | To | ☐ Yes | ☐ No |
| Work From | | To | ☐ Yes | ☐ No |

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

If leave buy back, also submit completed Form CA-7b.

**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 _____ Title **Injury Comp Specialist** Date / /

(*Agency Official*)

Name of Agency **Department of Resourcefulness**

Date Claim Form Received from Employee / /

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

Name **Same** Title _____

Telephone No. **(123) 456-8910** Fax No. **(123) 456-8911** E-Mail Address **N/A**

# Answer Key CA-7: Common Errors

- Section 1: Item c:  claim number missing
- Section 2: dates are missing as well as intermittent
- Section 6: Item b and c not completed
- Section 7: Not signed
- Section 8: Pay rates are missing
- Section 9: Fixed schedule is not marked
- Section 9b:  Did the employee work 11 months prior?
- Section 11: COP period is not indicated
- Section 12: Not completed
- Section 13: Return to work date and status are not completed
- Section 15: Not signed

# Questions

Form CA-7, Claim for Compensation is used to claim compensation for:

a) Wage loss while in a leave without pay (LWOP) status
b) Leave buy back
c) Schedule Award
d) Lost pay elements such as night differential, Sunday premium, and holiday pay
e) All of the above

# Questions

An employing agency should submit a completed Form CA-7 to OWCP within how many days of receipt from the injury worker?

a) 1 work day
b) 5 work days
c) 7 work days
d) 14 work days

# Questions

The Federal Employees' Compensation Act does not govern whether a claimant may or may not buy back leave from an employing agency. If the employing agency decides to move forward with a leave buy back, they will complete Form CA-7b. When OWCP processes the leave buy back, they will make a payment directly to:

a) The injured employee
b) The employing agency

# Questions

In order to process a Schedule Award, the medical evidence must describe:

a) That the specified member, organ, or function has reached a permanent and fixed state
b) The date of maximum medical improvement
c) The impairment in sufficient detail so OWCP can visualize the character and degree of impairment
d) A percentage evaluation of the impairment in terms of the affected member or function (not the body as a whole, except for the lungs) according to the 6th edition of the AMA Guides
e) All of the above

# Questions

The employing agency has many responsibilities when processing and completing Form CA-7, Claim for Compensation. All of the choices below represent an agency responsibility except:

a) Ensure the legibility and correctness of information supplied by the injured worker, including confirming they signed and dated the form

b) Provide the pay rate of the date of injury and date injured worker stopped work on the second page of the form

c) File Form CA-7 once a year if the injured worker continues to be disabled beyond the period claimed on the initial CA-7

d) Verify health and life insurance codes, along with the last date they were withheld by the employing agency

e) Supply a name and contact information for someone with knowledge of injured workers pay

# Questions

Form CA-7a, Time Analysis Form, is used to supplement Form CA-7 when disability/time loss from work is intermittent or for partial days. This includes time lost due to OWCP related medical appointments and treatment.

a) True
b) False

# Questions

The following elements of pay are all included when DFEC computes an employee's pay rate except:

a) Employee's full salary
b) Night differential
c) Premium pay for Sunday or holiday work
d) Hazard pay
e) Overtime pay

# Questions

There are two types of rolls when discussing wage loss payments; the daily roll and periodic roll. Which roll payment is used for payment of short periods of disability or intermittent hours of wage loss?

a) Daily roll
b) Periodic roll

# Take Away Tips

1) Form CA-7 is used to claim compensation for wage loss while in LWOP status, leave buy back, schedule award, and/or lost pay elements.

2) Employing agency (EA) should submit completed Form CA-7 to the Office of Workers' Compensation Programs (OWCP) within five work days of receipt from IW.

3) When an IW elects to use accrued sick or annual leave during a period of disability, he or she may later, with the concurrence of EA, claim compensation for the period of disability and "buy back" the leave used.

4) A schedule award provides compensation for the permanent loss or loss of use of specified members, functions, and organs of the body.

# Take Away Tips

5) Ensure the correctness of information supplied by IW.

6) Make certain the second page of the CA-7 form is completed accurately. Provide the pay rate for date of injury (DOI) and date IW stopped work.

7) Form CA-7a, Time Analysis Form, supplements Form CA-7 when disability/time loss from work is intermittent or for partial days.

8) Form CA-7b is an LBB worksheet which is completed by EA and it provides IW with an estimate of the cost to restore any sick/annual leave used as a result of the work injury.

# Take Away Tips

9) Pay rate for compensation is based upon Date of injury; Date that disability began; or Date of recurrence, when disability recurs at least 6 months after return to regular full time employment.

10) The basic compensation rate is 66 2/3%, which is increased to 75% if there is at least one eligible dependent.

11) OWCP deducts Health Benefits (HB) and Optional Life Insurance (OLI) premiums from the first day of wage loss if the employee was enrolled when disability began.