Miner's Claim for Benefits Under The Black Lung Benefits Act

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

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I hereby claim all benefits which may be payable to me under the Black Lung Benefits Act. I also hereby apply on behalf of my family for any benefits that may be payable under the Act.

OMB No. 1240-0038
Expires: 10/31/2026

IMPORTANT: No benefits may be paid under the Black Lung Benefits Act unless a completed application form has been received. Disclosure of your Social Security Number is voluntary; the failure to disclose your Social Security number will not result in the denial of any right, benefit, or privilege to which an individual may be entitled. The collection of the other information on this form is authorized by law (30 U.S.C. 901, et. seq.). This information is required to obtain a benefit. The Department of Labor conducts computer matches with the Social Security Administration. Any information provided by applicants or recipients of financial assistance or payments under Federal benefit programs may be subject to verification through computer matches that the Department of Labor conducts with these agencies.

(FOR DOL USE)

1. Miner's Full Name (First, Middle, Last) _____ _____ _____

2. Miner's Social Security Number

3. Mailing Address (Number, Street, Apt. No., P.O. Box or Rural Route) _____

4. City, State, & Zip Code _____

5. Miner's Email Address _____

6. Telephone Number (Include area code)

7. Miner's Date of birth (Month, day, year) _____

8. Highest grade miner completed in school _____

9. Have you (or someone on your behalf) ever filed a claim for Federal Black Lung benefits before? If yes, answer question 10.

☐ Yes ☐ No

10. Decision made (If more than one claim has been filed, identify, and show the disposition of each in Item 23, "Remarks,")

☐ Allowed ☐ Denied
☐ Withdrawn ☐ Pending

11. Are you still engaged in coal mine employment (in or around coal mines or a coal preparation facility in the extraction, transportation, or preparation of coal, or in coal mine construction or maintenance in or around a coal mine)? ☐ Yes ☐ No If no, answer a.

a. When did your coal mine employment end? Provide month, day, and year of last coal mine employment: _____

12. In what state of the United States were you working when your coal mine employment ended, or what state are you currently engaged in coal mine employment? _____

13. How many total years did you work in coal mine employment? _____

DISABILITY:

NOTE: If available evidence is insufficient to arrive at a determination, you may be requested to have an independent medical examination at no expense to you. Should the Department of Labor obtain information useful to your physician for treatment, such information may be furnished to the physician.

14. Describe briefly any disability you believe you have due to pneumoconiosis (Black Lung) or other respiratory or pulmonary disease resulting from coal mine employment. Specifically, what aspect(s) of your last coal mine employment job in the coal mines are you physically unable to perform as a result of your disability?

CURRENT EMPLOYMENT AND WAGES:

NOTE: The amount of your earnings, either as an employee or from self-employment, will help us determine the correct payment of black lung benefits to which you may be entitled. This information is required by the 1981 Amendments to the Black Lung Benefits Act.

15. Are you currently working? ☐ Yes ☐ No If yes, answer a.

a. Enter the names and addresses of all persons, companies, or government agencies for which you worked during the previous calendar year. If self-employed, so indicate.

Name and Address of Employer	Work Began Month/Year	Work Ended Month/Year	Approximate Annual Earnings

WORKERS' COMPENSATION:

NOTE: The amount of state or federal workers' compensation and/or occupational disease benefits you receive based on your disability due to coal workers' pneumoconiosis will be subtracted from your benefits under Part C of the Black Lung Benefits Act. This does not apply to benefits under the Longshore and Harbor Workers' Compensation Act (LHWCA) or Social Security Disability Insurance benefits for pneumoconiosis.

16. Have you filed a workers' compensation claim under any state or federal law on account of your disability, due to coal workers' pneumoconiosis?

☐ Yes ☐ No (If "Yes," complete items *a* through *k*.)

a. With what state or federal agency was the claim filed?

b. Approximate date of filing:

c. Claim No. (If known):

d. Decision made: ☐ Approved ☐ Denied ☐ Pending

(If approved, please provide a complete copy of your workers' compensation award.)

e. Employer against whom your workers' compensation claim was filed?

f. Amount of payment:

Weekly: $ per week

Other: $ per

g. Date payments began:

Date payments ended:

h. Did you pay any attorney fees or legal fees in securing your workers' compensation award?

☐ Yes ☐ No

i. If you received a lump sum payment based on your workers' compensation claim, please indicate the following:

Period covered: From: To:

Amount: $

j. Have you ever received medical benefits as part of your workers' compensation benefits? ☐ Yes ☐ No

k. Are you currently receiving medical benefits as part of your workers' compensation benefits? ☐ Yes ☐ No

DEPENDENTS:

17. Are you currently married? ☐ Yes ☐ No (if "Yes" Complete items *a-f*) (if "No" go to item 18).

a. Date of marriage

b. Your spouse's first and last name prior to marriage:

Social Security Number:

c. Spouse's birth date:

d. Do you reside with your spouse?

☐ Yes ☐ No (If "No," answer items *e* and *f*.)

e. Are you under a court order to make support payments to your current spouse?

☐ Yes ☐ No (If "Yes," attach a copy of the order.)

f. Do you make regular support payments to your current spouse?

☐ Yes ☐ No (If "Yes," indicate amount.)

$ per (week, month, other)

18. Have you ever been previously married? ☐ Yes ☐ No (If "Yes," answer *a* through *f*.)

a. Full Name of your previous spouse:

Social Security Number:

b. Date married: (MM/DD/YYYY)

c. Place married: (City & State)

d. How marriage ended: (death, divorce)

e. Date marriage ended: (MM/DD/YYYY)

f. Place marriage ended: (City, State)

If prior marriage ended by divorce and you were married for 10 years before the divorce action, answer questions 19 and 20.

19. Are you under a court order to make support payments to a divorced spouse?

☐ Yes ☐ No (If "Yes," attach a copy of the order).

20. Do you make substantial monetary contributions to a divorced spouse?

☐ Yes ☐ No (If "Yes," indicate amount)

$ per (week, month, other)

DEPENDENTS continued:

21. Please list all your **unmarried** children who fit into one of the following categories: currently under the age of 18; age 18 to 23 and attending full-time school; and age 18 or older and disabled. If you do not have any children that fit these categories, please skip to question 22. Use “remarks” space in item 23 if the space below is insufficient.

IF THERE ARE NO CHILDREN WHO FIT THESE CATEGORIES, SKIP TO 22.

Full Name of Child:	**Social Security Number**	**Date of Birth MM/DD/YYYY**	**Eligibility Category**	**Child’s relationship to you**
Last, First, Middle:			☐ Under age 18 ☐ Full-Time Student ☐ Disabled	☐ Biological ☐ Adopted ☐ Stepchild ☐ Other
Last, First, Middle:			☐ Under age 18 ☐ Full-Time Student ☐ Disabled	☐ Biological ☐ Adopted ☐ Stepchild ☐ Other
Last, First, Middle:			☐ Under age 18 ☐ Full-Time Student ☐ Disabled	☐ Biological ☐ Adopted ☐ Stepchild ☐ Other
Last, First, Middle:			☐ Under age 18 ☐ Full-Time Student ☐ Disabled	☐ Biological ☐ Adopted ☐ Stepchild ☐ Other

If any child named above does not live with you, enter the name and address of the person or organziation with whom the child lives. Please list this information under item 23 “remarks.”

IMPORTANT NOTICE

22. The events listed below may affect your eligibility or the amount of your Federal Black Lung benefits:

Your condition improves; or

You become entitled to state workers’ compensation or occupational disease payments due to disability on account of pneumoconiosis; or

The amount of any of the benefits described above to which you are entitled changes; or

You work in or around coal mines or any other employment, including self-employment.

The events listed below relating to your dependents may also affect the amount of your Federal Black Lung benefits:

A dependent marries, divorces, dies, or is adopted by someone else; or

A child age 18-23 stops attending school, or in the case of a disabled child 18 or older, the disabling condition improves.

It is **IMPORTANT** that you report **PROMPTLY** any of the above events that occur. Failure to report events promptly could result in an overpayment requiring repayment.

Do you agree to notify the Department of Labor if any of the above events occur? ☐ Yes ☐ No

23. Remarks. (You may use this space for explanations. If you need more space, attach a separate sheet.)

SIGNATURE OF MINER

I hereby certify that the information given by me on and in connection with this form is true and correct to the best of my knowledge and belief. I am also fully aware that any person who willfully makes any false or misleading statement or representation for the purpose of obtaining any benefit or payment under this title shall be guilty of a misdemeanor under 30 USC 941 and, on conviction, subject to a fine of not more than $1,000.00, or by imprisonment for not more than one year, or both. I authorize any physician, hospital, agency, employer or other organization (including the Social Security Administration) to disclose any medical records, or other information to the Department of Labor, Office of Workers’ Compensation Programs. Furthermore, I authorize the Department of Labor, Office of Workers’ Compensation Programs to disclose any medical or other information about the decision in your Black Lung Benefits claim to the Workers’ Compensation, Unemployment Compensation, or Disability Insurance agency of my State to use in connection with any claim with another agency.

24. Signature of Claimant (First, Middle, Last)	25. Date (Month, Day, Year)

Witnesses are required **ONLY** if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant must sign below, giving their full address.

26. Signature of witness	27. Signature of witness
28. Witness Address (Number, street, city, state & zip code)	29. Witness Address (Number, street, city, state & zip code)

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

PRIVACY ACT NOTICE

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) the Black Lung Benefits Act (BLBA) (30 U.S.C. 901 et seq.), as amended, is administered by the Office of Workers' Compensation Programs (OWCP) of the U.S. Department of Labor, which receives and maintains personal information, relative to this application, on claimants and their immediate families; (2) information obtained by OWCP will be used to determine eligibility for benefits payable under the BLBA; (3) information may be given to other government agencies, coal mine operators potentially liable for payment of the claim or to the insurance carrier or other entity which secured the operator's compensation liability, contractors providing automated data processing services to the Department of Labor; and representatives of the parties to the claim; (4) information may be given to physicians or other medical service providers for use in providing treatment, making evaluations and for other purposes relating to the medical management of the claim; (5) information may be given to the Department of Labor's Office of Administrative Law Judges, or other person, board or organization, which is authorized or required to render decisions with respect to the claim or other matters arising in connection with the claim; (6) information may be given to Federal, state or local agencies for law enforcement purposes, to obtain information relevant to a decision under the BLBA, to determine whether benefits are being or have been paid properly, and where appropriate, to pursue administrative offset and/or debt collection actions required or permitted by law; (7) disclosure of the claimant's or deceased miner's Social Security Number (SSN) or tax identifying number (TIN) on this form is voluntary, and the SSN and/or TIN and other information maintained by the OWCP may be used for identification and for other purposes authorized by law; (8) failure to disclose all requested information, may delay the processing of this claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits; and (9) this information is included in a System of Records, DOL/OWCP-2 published at 81 Federal Register 25765, 25858 (April 29, 2016) or as updated and republished.

Public Burden Statement

Public reporting for this collection of information is estimated to average 45 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Division of Coal Mine Workers' Compensation, Room C-3520, 200 Constitution Avenue, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**

Notice

If you have a substantially limiting physical or mental impairment, Federal disability nondiscrimination law gives you the right to receive help from OWCP in the form of communication assistance, accommodation and modification 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 account for the limitations of your disability. Please contact our office or the claims staff to ask for assistance.

TWO FILING OPTIONS:

1. To file electronically, submit completed form and accompanying documentation to the C.O.A.L. Mine Portal:
   https://coalmine.dol.gov

2. To file by mail submit completed form and accompanying documentation to:
   U.S. Department of Labor OWCP/DCMWC
   Central Mail Room
   PO Box 8307
   London, KY 40742-8307

   For further information call TOLL FREE: 1-800-347-2502