U.S DEPARTMENT OF LABOR
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

OMB No. 1240-0048
Expires: 11/30/2026

Instructions For Completion of Form CM-921

Reports of Coverage for Policies of Insurance Under the Black Lung Benefits Act (the Act), 30 U.S.C. 901-944.

Under the Act, each carrier or State fund providing coverage to operators under the provisions of the Act is required (20 CFR 726.208 - .213) to report to the Office of Workers' Compensation Programs each policy and endorsement issued by it to an operator who carries on coal mining operations in a named State or States. The report must be made on Form CM-921 and filed with the Office of Workers' Compensation Programs. A sample report (Form CM-921) is included for reference. Each carrier should complete the form at the beginning of a new coverage period and submit it to the U.S. Department of Labor, Office of Workers' Compensation Programs, Division of Coal Mine Workers' Compensation, 200 Constitution Avenue, N.W., Suite C3520-DCMWC, Washington, D.C. 20210, or file electronically by submitting to DCMWC-public@dol.gov.

IMPORTANT: Carriers are **NOT REQUIRED** to submit this form if the insured coal mining operations are conducted in a state that reports all workers' compensation insurance coverage to the National Council on Compensation Insurance (NCCI).

Cancellation of a contract or policy of insurance issued under the authority of the Act shall not become effective otherwise than as provided by the provisions under 33 U.S.C. 936(b), as incorporated by 30 U.S.C. 932(a), which requires that the carrier or State fund must submit a notice to the Office of Workers' Compensation Programs and to the operator of the proposed cancellation 30 days before such cancellation is intended to be effective.

1. NAME OF EMPLOYER - The correct name of the coal mine operator must be written in full, as well as the trade name, if the business is conducted under a trade name; if partnership, the correct partnership name must be shown.

a. A separate card report for each operator covered shall be submitted. The name of only one operator shall appear on each report.

EXAMPLE

All on one Card: WRONG	Southern Coal Company; John Brown and James Black T/A Brown and Black Company; and Brown and Black Southern Coal Company.
A Separate Card for Each:	(1) Southern Coal Company (2) John Brown and James Black T/A Brown and Black Company (3) Brown and Black Southern Coal Company

b. In no case shall the expression "et al" or similar abbreviations or indications of undisclosed operators be used. The correct name of the operator, whether individual, firm, or corporation, shall be shown.

2. FEDERAL EMPLOYER IDENTIFICATON NUMBER - List the operator's FEIN or Tax ID.

3. ADDRESS - The coal mine operator's address must be shown.

4. POLICY NUMBER - Current insurance policy number.

5. COVERAGE DATES - The beginning and expiration dates of policies must be clearly indicated. They should be written plainly, such as "July 1, 2017 to July 1, 2018" or other proper dates, and uncertain abbreviations avoided. For example, "7/1/17 - 18," would be considered uncertain. Policies should cover a period of one year; if report indicates a shorter term, a satisfactory letter of explanation should accompany the report.

6. STATES OF INSURED OPERATIONS - List all States with coal mine operations insured under the terms of the policy. List names, locations and MSHA ID of covered mines and subsidiaries.

7. INSURANCE CARRIER - No contract or policy of insurance issued by a State fund or carrier under the Act shall be cancelled prior to the date specified in each contract or policy for its expiration until at least thirty days have elapsed after a notice of cancellation has been sent to the OWCP and to the operator in accordance with the provision of 33 U.S.C. 936(b).

8. ADDRESS

9. TELEPHONE

10. SIGNATURE

a. Notification of cancellation or reinstatement of a policy must be sent to the OWCP in letter form. Cancellation by report form will not be accepted, and will be returned to the carrier.

b. When a rewrite of a policy is made, the report of the new insurance coverage should bear the statement, "rewrite of Policy Number _____." This information should be provided in the policy number box, in addition to the new policy number. This will prevent misunderstandings and avoid time-consuming correspondence to the carrier for explanations of existence of two or more policies.

REPORT - Each carrier has the responsibility for having Form CM-921 available for use by its own underwriting staff. The report is available online at https://www.dol.gov/sites/dolgov/files/owcp/regs/compliance/cm-921.pdf. Such report must be printed (at the carrier's own expense) in the following approved OWCP format. (See sample).

Notice of Issuance of Insurance Policy

1. Mine operator
2. Operator's Federal Employer Identification Number
3. Address (include Street, City, County, State, ZIP Code)
4. Policy Number
5. Policy Dates
a. Beginning
b. Ending

Report is made of this issue of approved form of policy and endorsement under the Black Lung Benefits Act. This report is authorized by law**. (30 U.S.C. 901 et seq.) Response is required by 20 C.F.R. 726.208 and is used to identify the insurance carrier.**

6. Coverage is provided for operations in the following states:

7. Insurance Carrier
8. Address
9. Telephone Number
10. Authorized Signature for Carrier _____

(DO NOT WRITE IN THIS SPACE)

OWCP No.:
Cancel Date:

Completed card should be forwarded to the U.S. Department of Labor, Office of Workers' Compensation Programs, Division of Coal Mine Workers' Compensation, 200 Constitution Avenue, N.W., Suite C3520-DCMWC, Washington, D.C. 20210. or filed electronically by submitting to DCMWC-public@dol.gov.

(COMPLETE REVERSE SIDE)

Indicate below the name and location of the insured mine(s) and subsidiaries

NAME, LOCATION, and MSHA ID OF MINE	NAME AND LOCATION OF SUBSIDIARY

Public Burden Statement

Public reporting burden estimate for this collection of information is 10 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, 200 Constitution Avenue, N.W., Suite C3520-DCMWC, Washington, D.C. 20210. **NOTE: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**