Survivor's Form For Benefits Under The Black Lung Benefits Act

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U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

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(For Agency use only)

If you are a survivor of a person who was receiving Federal black lung benefits resulting from a claim filed before 1982, this form is a Survivor's Notification of the Beneficiary's Death. Otherwise, this is a claim for survivor's benefits. This form is authorized by the Black Lung Benefits Act (30 U.S.C. 901, et seq.) and by 20 C.F.R. 410.221 and 20 C.F.R. 725.304. This information will be used to determine possible eligibility for and the amount of benefits payable under the Act. Benefits may be payable to you, your children and all children of the deceased miner. The information on this form is required to obtain a benefit. However, disclosure of your or the deceased miner's Social Security Number is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled.

1. Deceased Coal Miner's Name: (First, Middle, Last)

2. Deceased Coal Miner's Social Security Number:

3. COAL MINER's BIRTH AND DEATH DATES (ATTACH DEATH CERTIFICATE, IF AVAILABLE)

Date of birth: | Date of death: | Autopsy? ☐ Yes ☐ No

4. Your name: First Middle Last

5. Your Social Security Number:

6. Your date of birth:

7. SHOW YOUR RELATIONSHIP TO THE MINER

☐ Surviving Spouse (wife or Husband) ☐ Dependent Child

☐ Surviving Divorced Spouse ☐ Dependent Parent, Brother or Sister

8. Have you or the miner ever filed a State or Federal workers' compensation claim for death or disability due to coal workers' pneumoconiosis (Black Lung) or any other lung conditions?	☐ Yes	☐ No
9. Have you or any dependent of the miner ever received Federal Black Lung Benefits under **another miner's Social Security number?**	☐ Yes	☐ No

• IF YOU ARE FILING AS A CHILD, PARENT, BROTHER OR SISTER, GO TO QUESTION 12.

10. **Do you or the miner have any dependent children under age 18, age 18 to 23 and attending school, 18 or older and disabled?**	☐ Yes	☐ No
11. **Were you or the miner ever married to anyone else at anytime?**	☐ Yes	☐ No
12. **Do you authorize any physician, hospital, agency or other organization (including Social Security Administration) to disclose to the Department of Labor any medical records or information important to your claim?**	☐ Yes	☐ No
13. **The following events may affect your entitlement to Federal Black Lung Benefits. Do you agree to notify the U.S. Department of Labor promptly if any of the events listed below occur?**	☐ Yes	☐ No

- **You become entitled to receive any workers' compensation or occupational disease payments because of the miner's disability or death due to pneumoconiosis (Black Lung Disease).**
- **A person receiving benefits marries, dies, or is adopted by someone else, becomes disabled or the existing disability ceases, or if divorced, receives support payments from previous spouse.**
- **A child (age 18-23) stops attending school, or in the case of the disabled child (age 18 or over), the disabling condition improves.**

(PLEASE COMPLETE THE OTHER SIDE OF THIS FORM)

PRIVACY ACT NOTICE

In accordance with the Privacy Act of 1974 (5 U.S.C. 552a), as amended, 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 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; (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, other than the SSN or TIN, may delay the processing of this claim or the payment of benefits or may result in an unfavorable decision or reduced level of benefits.

COMPUTER MATCHING PROGRAM. The Department of Labor conducts computer matches with the Social Security Administration. Any information provided by applicants for and recipients of financial assistance or payments under Federal benefit programs may be subject to verification through computer matches which the Department of Labor conducts with the Social Security Administration.

SIGNATURE OF APPLICANT

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 and on conviction thereof shall be punished by a fine of not more than $1,000, or by imprisonment for not more than one year or both.

Signature in ink (First, Middle, Last)	Date
Mailing Address (Number, Street, Apt. No., PO Box, Rural Route)	County you live in
City, State, ZIP Code	Area Code and Telephone Number

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.

Signature of Witness	Signature of Witness
Address of Witness	Address of Witness
City, State, ZIP Code	City, State, ZIP Code

Public reporting for this collection of information is estimated to average 8 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 U. S. Department of Labor, Division of Coal Mine Workers' Compensation, 200 Constitution Avenue, Room C-3520, Washington, DC 202 1 0. DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.

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