Request for State or Federal Workers' Compensation Information

U.S. DEPARTMENT of LABOR

Employment Standards Administration
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

The requested information is needed to process a claim under the Black Lung Benefits Act (30 U.S.C. 901 et. seq.). While completion of this form is voluntary, cooperation is needed in returning this form to determine the claimant's eligibility under the Act.

OMB No. 1215-0060
Expires: 09/30/2007

. **IDENTIFICATION OF MINER** (To be completed by DOL Claims Examiner)

TO:

1a. Name of Miner (First, Middle, Last)

b. Name of Claimant (if different from miner)

2.Address(Number, street, city, state, Zip code)

3. Employer's Name and Address

4. Miner's Social Security Number

5. State or Federal Claim Number(s)

6. Signature of DOL Claims Examiner

7. Date(Month, day, year)

II. **WORKERS' COMPENSATION INFORMATION** (To Be completed by a State or Federal Workers' Compensation official)

Please complete all items as appropriate including item 5 if no claim number is provided. Forward the original to the Division of Coal Mine Workers' Compensation and retain a copy in your files for use in notifying the DCMWC of any changes in the beneficiary's workers' compensation status or rate.

8. Has the miner or his widow filed a claim for workers' compensation benefits due to pneumoconiosis or other chronic lung disease?

[ ] Yes [ ] No (if "Yes", complete items 9,10 and 11, as appropriate.)

9. Status of Claim:

[ ] Approved [ ] Denied [ ] Pending

10. Payment Information

a. Date began: _____
b. Expiration Date: _____
c. Weekly Amount $_____
d. Lump sum amount $ _____ representing settlement at $_____ per week for ___ weeks beginning _____
e. Date of Lump sum payment: _____
f. Are medical treatment expenses covered? [ ] Yes [ ] No

11.Were Fees or Expenses paid out of the Award?

a. attorney fees
[ ] Yes $ _____ amount
[ ] No
[ ] Unknown

b. Other extraordinary expenses (if "Yes" explain under "Remarks")
[ ] Yes $_____ amount
[ ] No
[ ] Unknown

12. Remarks:

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

13. Signature and Title

14 Date (Month, day, year)

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time or 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 N-3464, 200 Constitution Avenue, N. W., Washington, D.C. 20210. **DO NOT SEND THE COMPLETE FORM TO THIS OFFICE**

Original - Return to DCMWC Copy – Retain for Status or Rate Change Notification

CM-905
Rev. July 2007

Persons are not required to respond to this collection of information unless it displays a current valid OMB Control Number