U.S. DEPARTMENT OF LABOR **Employment Standards Administration**
Office of Workers' Compensation
Division of Coal Mine Workers' Compensation
REMAINDER OF ADDRESS FOR SPECIFIC OFFICE
AND TELEPHONE NUMBER

PLEASE KEEP THIS FOR YOUR RECORDS AND FOR FUTURE REFERENCE.

Instructions

Complete, sign, date, and return the enclosed **REPORT OF CHANGES** form, *in the envelope provided*, to your Black Lung District Office within 30 days of receipt. The form contains information the Department of Labor has concerning the beneficiary's Black Lung benefits claim. If the information is not correct, please supply the correct information in the spaces provided on the form.

Failure to return this form could result in the suspension or termination of benefits.

If you have any questions about this form, please call your Black Lung Office at the toll-free 800-number appearing at the top of this page.

REPORTING REQUIREMENTS

The law requires you to report immediately any of the following events regarding the beneficiary:

1. Marriage	7. Change in school attendance of dependent children age 18 or older
2. Divorce	8. Return to work
3. Birth or adoption of dependent child	9. Increased earnings
4. Marriage of dependent child	10. Filing for or receipt of State of other Federal Workers' Compensation Benefits
5. Death of spouse/child	
6. Disability of child (any age)	

These events could affect the amount of the beneficiary's monthly check. If not reported timely and the beneficiary is overpaid, you may have to pay back the benefits that you incorrectly received. If the information on the form is not correct, you must correct that information.

Your Responsibility as a Representative Payee

Your job as a representative payee is to use the Black Lung benefits you receive for the personal care and well-being of the beneficiary. You must keep yourself informed of the beneficiary's needs so you can decide how the benefits should be used. You must contact the U.S. Department of Labor when the beneficiary changes residence or if you no longer exercise responsibility for the care and welfare of the beneficiary. You must report the beneficiary's death, marriage, adoption, employment, or release from a hospital or institution. You must also report the beneficiary's receipt of any State Workers' Compensation Benefits and changes in school attendance or disability status, if the person for whom you receive benefits is a student or disabled.

Whoever, having received a payment for the use and benefit of another person, knowingly and willfully uses such payment for other than the use and benefit of the person for whom it is received, is subject to a fine, or imprisonment or both. Benefits shall be held in an interest bearing account which shows that the money belongs to the beneficiary, i.e., "Your name for beneficiary", "Beneficiary's name by your name", "Your name on-behalf-of (OBO) beneficiary," etc. If you are not sure whether the account you have established shows this ownership, you should consult your bank and, if necessary, change the account title appropriately.

Representative Payee Reporting Instructions

All representative payees are required to account annually. This is your Representative Payee Report. You must complete and return the report whether you are the beneficiary's relative, friend, or court-appointed guardian, or you are an official of a bank or a public or private agency or institution. You should keep a record of the amount of benefits you received and how you used them, because the report will be reviewed by the U. S. Department of Labor and is subject to verification. You will be notified if verification is required. DO NOT submit receipts, canceled checks, etc., with this report. If you need help completing the report, please contact the office listed above by mail or telephone. THIS REPORT MUST BE COMPLETED AND RETURNED WITHIN THIRTY DAYS OR BENEFITS MAY BE AFFECTED.

Medical Benefit Information

If the beneficiary is a miner, the Black Lung Disability Trust Fund is responsible for payment of his black lung-related medical expenses. However, if the beneficiary also receives benefits for a black lung condition from a state or another Federal workers' compensation program, the black lung-related medical expenses may be paid, partially or totally, by the party who pays those benefits.

Unless another party is responsible for payment of the black lung-related medical expenses, the miner should continue to use the Black Lung Identification Card (the red and white card) when receiving medical treatment for his/her black lung condition. Examples of black lung-related medical services are: hospitalizations, doctor's office visits, medically prescribed drugs, certain types of medical equipment (such as oxygen machines), home nursing services, pulmonary rehabilitation, and the reasonable cost for travel to and from a medical facility for the treatment of the black lung condition. If you have any questions concerning the medical coverage for the miner's black lung condition, you should contact your Black Lung District Office at the toll-free 800-number appearing at the top left corner of page 1.

Computer Matching Program

The Department of Labor will match this information by computer with the Social Security Administration. Any information provided by applicants for and recipients of financial assistance or payments under Federal benefits programs may be subject to verification by Department of Labor computer matches with these agencies.

PAPERWORK / PRIVACY ACT NOTICE

The following statement is made in accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a). This report is authorized by law (30 USC 922 section 20 CFR 725.513). Your cooperation is needed to insure that Black Lung benefits are being received in the correct amount and that the beneficiary's needs are being met. Failure to provide all or part of the information could prevent an accurate and timely decision as to your continued suitability as representative payee. The information you furnish on this form may be routinely disclosed without your consent to another person or government agency for purposes such as (1) to comply with Federal laws requiring the release of information from our records; or (2) to conduct research and audit activities needed to assure the continuing integrity and improvement of the U.S. Department of Labor representative payee program. Other routine disclosures of information are listed in the Federal Register, which will be made available upon request.

PUBLIC BURDEN STATEMENT

We estimate that it will take 6 -80 minutes per response to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them 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 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.

U.S. Department of Labor
ESA/OWCP/DCMWC
200 Constitution Ave. NW
Washington, DC 20210

Report of Changes That May Affect Your Black Lung Benefits

Department of Labor OMB No.: 1215-0084
Expires:

Rep Payee's Name Telephone: xxx-xxx-xxx
Address

Beneficiary Name Telephone: xxx-xxx-xxx
Address

xxx-xx-1234

IMPORTANT NOTICE: **This ANNUAL REPORT OF CHANGES must be completed, signed, dated, and returned within thirty (30) days of receipt.** Below, you will find information about the the beneficiary's Federal Black Lung Benefits. IF THE INFORMATION IS NOT CORRECT OR IF YOU HAVE CHANGES TO REPORT, ENTER THE NEW INFORMATION IN THE SPACE PROVIDED BELOW EACH STATEMENT OR QUESTION.

1. If you or the beneficiary have changed an address or telephone number, please provide the new information below. Even if black lung benefits are received by direct deposit, we must have correct addresses so we can send letters and other important information.

   ADDRESS: ____

   ____

   ____ **TELEPHONE NUMBER**:____________________

2. Please list below the name and telephone number of a relative or close friend whom you would wish us to contact if you were unable to contact us regarding the beneficiary's benefits.

   ____

3. The monthly black lung benefit payment for the beneficiary is $ **xxxxx.**

4. Check the proper box below regarding any changes to the beneficiary's marital status in the last year.

   □ No change in the last year (If you check this block, please proceed to question #5)

   □ Death of Spouse – Date of death _________________

   □ Separation from Spouse – Date of Separation ______________

   □ Divorce – Date of Divorce _________________

   □ Marriage – Date of Marriage ___________ Name of Spouse _________________________

   Social Security Number of Spouse_________________________

5. During the last twelve months, if any children who receive FEDERAL BLACK LUNG benefits along with the beneficiary had a change in their condition(s), please provide the following information.

Child's name	Date of Birth	Date of Marriage	Date School Attendance Ended	Date Disability Began	Date of Death
xxxx	**xxxx**				

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6. In addition to BLACK LUNG Benefits, if the beneficiary also receives payment from another FEDERAL or a STATE Workers' Compensation program, please provide the following information.

Amount received from other Federal or State Compensation program: $______________;

How often do you receive this benefit? ☐ WEEKLY ☐ EVERY TWO WEEKS ☐ MONTHLY

7. FOR COAL MINERS UNDER AGE 65, AND DISABLED ADULT CHILDREN, ONLY: If the beneficiary is working and earning money from any type of employment, please give us the following information.

Employer: ____

Total earnings last calendar year: $___________

Estimated earnings for this year: $____________

Beneficiary-Representative Payee Relationship

8. Check below all places the beneficiary lived during the report period shown above.

☐ With you (private residence) – **Go to question 9 below.**

☐ Any other location – **Go to questions 10 through 18 (Skip question 9)**

9. **NOTE: After answering this question, go next to question 19 (skip questions 10 through 18)**

a. Have you lived in the same household as the beneficiary for the entire period? If no, please explain under comments below. ☐ Yes ☐ No

b. How are you related to the beneficiary? ____

c. Were all of the beneficiary's benefits received during this period used or saved for the beneficiary? If no, please explain under comments below. ☐ Yes ☐ No

d. Were the benefits spent for the beneficiary on items other than food, shelter and personal needs? If yes, please explain below under comments. ☐ Yes ☐ No

Comments____

10. Give the name and address of each person with whom the beneficiary lived during the reporting period.

Name and Address	Date of residence:	
	From:	To:
	From:	To:

11. How did you find out what the beneficiary's needs were, if the beneficiary did not live with you?

12. Do you maintain contact with the beneficiary by:

Letter? ☐ Yes ☐ No	Visit? ☐ Yes ☐ No	Telephone? ☐ Yes ☐ No	Email? ☐ Yes ☐ No

Black Lung Benefit Accounting

We advised when you were selected as representative payee for the beneficiary, that you are required to account annually for the Federal Black Lung benefits received and spent. Please complete the following questions; DO NOT submit receipts, cancelled checks, etc., with this report. (You will be notified later if verification is required)

ACCOUNTING FOR THE PERIOD: xx/xx/xxxx TO: xx/xx/xxxx

13. Funds on hand from Black Lung benefits at beginning of this report period: If you have filed a previous U.S. Department of Labor Black Lung Representative Payee accounting report, this amount should be the same as the figure shown on your last report (item 18) as remaining balance.	$ __ __,__ __ __.__ __
14. Total Black Lung benefits received during the reporting period:	**$ __ __,__ __ __.__ __**
15. Total Black Lung funds available during this reporting period: (Item 13 plus 14)	$ __ __,__ __ __.__ __
16. How available Black Lung benefits were used during the reporting period:	
a. Amount used for beneficiary's food and shelter: (Show in "REMARKS" section of this report the name and address of the any person or entity receiving food and shelter payments.)	$ __ __,__ __ __.__ __
b. Amount used for beneficiary's clothing:	$ __ __,__ __ __.__ __
c. Amount used for beneficiary's medical and dental care:	$ __ __,__ __ __.__ __
d. Amount used for personal needs of the beneficiary:	$ __ __,__ __ __.__ __
e. Amount used for support of beneficiary's dependents:	$ __ __,__ __ __.__ __
f. Amount used for other items: (show purpose for which funds were used in "REMARKS" section of this report):	$ __ __,__ __ __.__ __
17. Total amount used during the reporting period (Add 16a through 16f):	$ __ __,__ __ __.__ __
18. Balance remaining at the end of this period (item 15 minus item 17)	$ __ __,__ __ __.__ __

19. How is balance of the funds, if any, held, saved, or invested?

	AMOUNT	TITLE/OWNERSHIP Name(s) that appears on each account. *
Cash:	$ ________	________
Checking Account:	$ ________	________
Insured savings account:	$ ________	________
U. S. Savings Bonds:	$ ________	________
Other (Specify):	$ ________	________

* Benefits shall be held in an interest bearing account which shows that the money belongs to the beneficiary, i.e., "Your name for beneficiary", "Beneficiary's name by your name", "Your name on-behalf-of (OBO) beneficiary," etc. If you are not sure whether the account you have established shows this ownership, you should consult your bank and, if necessary, change the account title appropriately.

20. If all benefits received during this reporting period were held, saved, or invested, please explain how the beneficiary's needs were met:

21. During this period, did the beneficiary have any other benefits/income than U.S. Department of Labor Black Lung Benefits? ☐ Yes ☐ No If "Yes", please indicate the source of the income:

Source____ Amount__________________

Frequency of Payment____

Source____ Amount__________________

Frequency of Payment____

22. Have you ever been convicted of a felony? ☐ Yes ☐ No If yes, explain below in remarks section.

REMARKS:

23. THIS FORM MUST BE SIGNED AND DATED.

I CERTIFY THAT ALL OF THE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. If you conceal or fail to disclose a reporting event with an intent to obtain benefits fraudulently, either in a greater amount or when no payment is authorized, you may be fined, imprisoned, or both, as provided in 30 U.S.C. 941. The penalty for the misuse of benefits by a representative payee is a fine and/or imprisonment for up to five (5) years for the first offense, pursuant to Public Law 98-450. A second offense is punishable by up to five (5) years of imprisonment and/or a fine not exceeding $25,000. The court may also order restitution.

____ ___________________________

Representative Payee's Signature/Mark Date

Witness signatures are required only if the payee's signature above has been signed by mark (X).

____ ____

Witness' Signature Date Witness' Signature Date

COMMENTS/ADDITIONAL INFORMATION: