OPERATOR RESPONSE TO SCHEDULE FOR SUBMISSION OF ADDITIONAL EVIDENCE

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



Miner's Name		Claimant's Name		Claim Number		OMB No. 1215-0058 Expires: 09-30-04
Responsible Operator's Name			Insurer's Name		Poli	cy No.
approprissuanto have determ	port is authorized by the Black Lung Benefits Act as riate boxes below. While you are not required to roce of the schedule for the submission of additional accepted liability for this claim (that is, that you ined to be entitled) and to have waived your right claim. You also will be deemed to have contested	espond. If al evidence will be res to contest	you fall to do so we naming you as a ponsible for paym your liability in an	rithin 30 days after the responsible operator ent of benefits to wh y further proceeding	e Disti , you s ich the	rict Director's shall be deemed e Claimant is finally
A. Liak	oility					
The nar	ned responsible operator:					
	Agrees it is the responsible operator within the meaning of the Black Lung Benefits Act, liable for any benefits to which the claimant is finally determined to be entitled.					
	Disagrees with its designation as the responsible operator liable for this claim.					
relevant eviden	isagree, the schedule for the submission of additional event to your liability, subject to the limitations imposed by 20 ce pertaining to liability shall be admitted in any futed to the district director in compliance with a sc	C.F.R. 725.4 Irther prod	408(b)(2). Absent ext ceeding conducted	raordinary circumstance with respect to this	es, no d claim u	locumentary
B. Clai	mant's Entitlement					
The nar	ne responsible operator:					
	Accepts the Claimant's entitlement to benefits.					
	Contests the Claimant's entitlement to benefits.					
time pe	o not accept the Claimant's entitlement to benefits, the s riod within which you may submit evidence relevant to th leemed to have contested the Claimant's entitlement to b	e Claimant's				
Name a	and Address of Firm Completing Form	Name of F	Person Completing Fo	rm		
		Title				
		Signatur	е	Date	9	

Public Burden Statement

We estimate that it will take an average of 20 minutes 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 the burden estimate or any other aspect to 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 C-3526, 200 Constitution Avenue, N.W., 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.