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

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

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.

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 this page.

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. 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 an average of 5 - 8 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
OWCP/DCMWC
200 Constitution Ave. NW
Washington, DC 20210

Report of Changes That May Affect Your Black Lung Benefits

U.S. Department of Labor

OMB No.: 1240-0028
Expires: xx-xx-xxxxx

Beneficiary's Name Telephone No.

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 your 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 have changed your address or telephone number, please provide the new information below. Even if you receive your black lung benefits by direct deposit, we must have your correct address so we can send letters and other important information to you.

   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 call or write us regarding your black lung benefits.

   _____

3. Your monthly black lung benefit payment is $.

4. Check the proper box below regarding any changes to your 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 you 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/Ended	Date of Death

6. In addition to BLACK LUNG Benefits, if you also receive 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 you are 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: $_____

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.

_____ _____

Beneficiary's Signature or "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

Reason beneficiary did not sign or make mark:

_____

_____

COMMENTS/ADDITIONAL INFORMATION: