Print Reset

Notice of Termination, Suspension, Reduction, or Increase In Benefit Payments

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

Privacy Act Statement: In accordance with the Privacy Act of 1974, as amended, (5 U.S.C. a), you are hereby notified that: This report is required by the Black Lung Benefits Act (30 U.S.C. 90 1 et. seq.) and is mandatory. It is to be completed in full and filed with the Office of Workers' Compensation Programs within 16 days following the termination of benefits, and immediately following the suspension, reduction or increase of benefits are paid under Title IV of the Federal Mine Safety & Health act of 1977, as amended to insure that correct benefits are paid. Failure to report can result in a civil penalty of not more than $500 for each such failure or refusal.

OMB No. 1240-0030
Expires: XX-XX-XXXX

Name and Address of Payee (Please Print) Include ZIP Code

Name

Address Line 1

Address Line 2

City State ZIP

Distribution:
Copy 3 - Payee's Copy
Copy 2 - Operator's Copy
Copy 1 - Send To:

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

1. Name of disabled or deceased miner

2. DOL Claim Number

3. Name of coal miner operator

4. Name of insurance carrier

5. Action taken: ☐ Terminated ☐ Suspended ☐ Reduced ☐ Increased

6. Reasons why action taken:

a. Date of Last Payment (mm/dd/yy)	**b.** Amount of Last Payment	**c.** Amount of Reduced/ Increased Payment	**d.** Date Benefits Will Resume (mm/dd/yy)	**e.** Date of This Notice (mm/dd/yy)

7. Summary of Payments

a. Name of Payee	**b.** From	**c.** To	**d.** Date Benefits Will Resume	**e.** Amount Paid Per Month	**f.** Total

8. Signature of person issuing this notice

9. Title

10. Telephone number

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 12 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 the Office of Workers' Compensation Programs, U.S. Department of Labor, Room C-3520, 200 Constitution Avenue, NW., Washington, DC. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**

Notice

If you have a substantially limiting physical or mental impairment, Federal disability nondiscrimination law gives you the right to receive help from DCMWC in the form of communication assistance, accommodation and modification to aid you in the claims process. For example, we will provide you with copies of documents in alternate formats, communication services such as sign language interpretation, or other kinds of adjustments or changes to account for the limitations of your disability. Please contact our office or your claims examiner to ask about this assistance.

Note: According to the Paperwork Reduction Act of 1995, persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.