

# Survivor's Form For Benefits Under The Black Lung Benefits Act

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



If you are a survivor of a person who was receiving Federal black lung benefits, this is a Survivor's Notification of the Beneficiary's Death. Otherwise, this is a claim for survivor's benefits. This form is authorized by the Black Lung Benefits Act (30 U.S.C. 901, et seq.) and by 20 C.F.R.725.304. This information will be used to determine possible eligibility for and the amount of benefits payable under the Act. Benefits may be payable to you, your children and all children of the deceased miner. The information on this form is required to obtain a benefit. However, disclosure of your or the deceased miner's Social Security Number is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled.

OMB No: 1240-0027  
Expires: XX/XX/XXXX  
**(For Agency Use Only)**

|    |  |  |   |      |
|----|--|--|---|------|
| 1. | Deceased Coal Miner's Name:  | First  | Middle  | Last |
| 2. | Deceased Coal Miner's Social Security Number:  |  |   |      |
| 3. | COAL MINER'S BIRTH AND DEATH DATES (ATTACH DEATH CERTIFICATE, IF AVAILABLE)  |  |   |      |
|    | Date of birth:   | Date of death:   | Autopsy? <input type="checkbox"/> Yes <input type="checkbox"/> No |      |
| 4. | Your name:   | First  | Middle  | Last |
| 5. | Your Social Security Number:   | 6. Your date of birth  |   |      |
| 7. | SHOW YOUR RELATIONSHIP TO THE MINER  |  |   |      |
|    | <input type="checkbox"/> Surviving Spouse (wife or husband)  | <input type="checkbox"/> Dependent Child                     |   |      |
|    | <input type="checkbox"/> Surviving Divorced Spouse   | <input type="checkbox"/> Dependent Parent, Brother or Sister |   |      |
| 8. | Have you or the miner ever filed a State or Federal workers' compensation claim for death or disability due to coal workers' pneumoconiosis (Black Lung) or any other lung conditions? | Yes  | No  |      |
| 9. | Have you or any dependent of the miner ever received Federal Black Lung Benefits under <b>another miner's Social Security number</b> ?   | Yes  | No  |      |

• **IF YOU ARE FILING AS A CHILD, PARENT, BROTHER OR SISTER, GO TO QUESTION 12.**

|  |     |    |
|--|-----|----|
| 10. Do you or the miner have any dependent children under age 18; age 18 to age 23 and attending school; age 18 or older and disabled?   | Yes | No |
| 11. Were you or the miner ever married to anyone else at any time?   | Yes | No |
| 12. Do you authorize any physician, hospital, agency or other organization (including Social Security Administration) to disclose to the Department of Labor any medical records or information important to your claim? | Yes | No |
| 13. The following events may affect your entitlement to Federal Black Lung Benefits. Do you agree to notify the U.S. Department of Labor promptly if any of the events listed below occur?                               | Yes | No |

- You become entitled to receive any workers' compensation or occupational disease payments because of the miner's disability or death due to pneumoconiosis (Black Lung Disease).
- A person receiving benefits marries, dies, or is adopted by someone else, becomes disabled or the existing disability ceases, or if divorced, receives support payments from previous spouse.
- A child (age 18-23) stops attending school, or in the case of the disabled child (age 18 or over), the disabling condition improves.

PRIVACY ACT NOTICE

- The following information is provided in accordance with the Privacy Act of 1974, 5 U.S.C. 552a. (1) Collection of this information is authorized by the Black Lung Benefits Act 30 U.S.C. 901 et. seq. and implementing regulations. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) This information may be used by other agencies or persons handling matters relating, directly or indirectly, to processing this form including liable coal mine operators and their insurance carriers; contractors providing automated data processing or other services to the Department of Labor; representatives of the parties to the claim; and federal, state or local agencies. This would include legal representatives; state workers' compensation agencies or the Social Security Administration, for the purpose of determining benefit payment offsets; the Internal Revenue Service and other federal, state, and local agencies for the purpose of conducting investigations relating to the payment of benefits; and debt collection agencies and credit bureaus for the purpose of collecting overpayments that might be made to the beneficiary. (4) Furnishing all requested information will facilitate the claims adjudication process, and the effects of not providing all or any part of the requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits. (5) This information is included in two Systems of Records, DOL/OWCP-2 and DOL/OWCP-9, published at 81 Federal Register 25858 and 25866 (April 29, 2016), or as updated and republished.

COMPUTER MATCHING PROGRAM. The Department of Labor conducts computer matches with the Social Security Administration. Any information provided by applicants for and recipients of financial assistance or payments under Federal benefit programs may be subject to verification through computer matches which the Department of Labor conducts with the Social Security Administration.

SIGNATURE OF APPLICANT

I hereby certify that the information given by me on and in connection with this form is true and correct to the best of my knowledge and belief. I am also fully aware that any person who willfully makes any false or misleading statement or representation for the purpose of obtaining any benefit or payment under this title shall be guilty of a misdemeanor and on conviction thereof shall be punished by a fine of not more than \$1,000, or by imprisonment for not more than one year or both.

|   |                                |
|---|--------------------------------|
| Signature in ink (First, Middle, Last)                          | Date                           |
| Mailing Address (Number, Street, Apt. No., PO Box, Rural Route) | County you live in             |
| City, State, ZIP Code   | Area Code and Telephone Number |

Witnesses are required only if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant must sign below, giving their full address.

|                       |                       |
|-----------------------|-----------------------|
| Signature of Witness  | Signature of Witness  |
| Address of Witness    | Address of Witness    |
| City, State, ZIP Code | City, State, ZIP Code |

**WHERE TO MAIL THIS FORM:**

Submit completed form with accompanying documentation to:  
 US Department of Labor  
 OWCP/DCMWC  
 PO Box 33610  
 San Antonio TX 78265

Public reporting for this collection of information is estimated to average 8 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 U. S. Department of Labor, Division of Coal Mine Workers' Compensation, 200 Constitution Avenue, Room N-3464, Washington, DC 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.

Notice

If you have a disability, federal law gives you the right to receive help from the OWCP in the form of communication assistance,

accommodation(s) and/or modification(s) to aid you in the OWCP 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 of changes to accommodate your disability. Please contact our office or your OWCP claims examiner to ask about this assistance.

---