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

This report is required by the Black Lung Benefits Act (30 U.S.C. 901 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 being paid under the Black Lung Benefits Act to insure that correct benefits are paid. Failure to report can result in a civil penalty as set forth in 20 CFR 725.621 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 City

Address Line 2 State ZIP

Payee E-mail Address

Distribution copies to: Payee, Operator and Department of Labor

Two Filing Options:

1.To file electronically, submit completed form to the COAL Mine Portal: https://eclaimant.dol-esa.gov/bl2.To file by mail, submit completed form to:
OWCP/DCMWC/CMR
Correspondence
PO Box 8307
London, KY 40742-8307

1. Name of disabled or deceased miner

2. DOL's CASE ID 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/yyyy)	**b.** Amount of Last Payment	**c.** Amount of Reduced/ Increased Payment	**d.** Date Benefits Will Resume (mm/dd/yyyy)	**e.** Date of This Notice (mm/dd/yyyy)

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 and address of person issuing this notice

Signature

Address Line 1

Address Line 2

City State ZIP

9. Title

10. Telephone number

11. E-mail Address

Public Burden Statement

Public reporting burden for this collection of information is estimated to be 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.

U.S. GPO:2001-479-595/89873

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 (20 CFR 725.621). (2) The purpose of the collection of information is to provide notification to the Department of Labor of a change in the beneficiary's benefit amount and the reason for the change. Completion of this form is mandatory. Failure to report can result in a civil penalty as set forth in 20 CFR 725.621 for each such failure or refusal. (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 as specified under the Black Lung Benefits Act; 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 accurate and timely determination of the beneficiary's benefit amount. (5) This information is included in a System of Records, DOL/OWCP-2, published at 81 Federal Register 25765, 25858 (April 29, 2016), or as updated and republished.