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

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PLEASE KEEP THIS FOR YOUR RECORDS AND FOR FUTURE REFERENCE.

Instructions For CM-929

Complete, sign, date, and return the enclosed **REPORT OF CHANGES** form within 30 days of receipt. Instructions on how to submit the form online or by mail are on page 3. The form contains information the Department of Labor has concerning your 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 nearest Black Lung Office at the toll-free 800-number shown in the list on the following page.

REPORTING REQUIREMENTS

The law requires you to report immediately any of the following events:

Marriage Divorce Birth or adoption of dependent child Marriage of dependent child Death of spouse/child Disability of child (any age)	Change in school attendance of dependent children age 18 or older Return to work Increased earnings Filing for or receipt of state or other federal workers' compensation benefits

These events could affect the amount of your monthly check. If not reported timely and you are 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 you are a miner, the Black Lung Disability Trust Fund is responsible for payment of your black lung-related medical expenses. However, if you also receive 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, you should continue to use the Black Lung Identification Card when receiving medical treatment for your 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.

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.

BLACK LUNG DISTRICT OFFICE TOLL-FREE NUMBERS

Greensburg, PA	800-347-3753	Johnstown, PA	800-347-3754
Charleston, WV	800-347-3749	Parkersburg, WV	800-347-3751
Mt. Sterling, KY	800-366-4628	Pikeville, KY	800-366-4599
Denver, CO	800-366-4612	Columbus, OH	800-347-3771
Washington, DC	800-347-2503		

PRIVACY ACT NOTICE

The following statement is made in accordance with the Privacy Act of 1974, 5 U.S.C. 552a. This report is authorized by law (30 U.S.C. 922 and 20 CFR 725.533(e)). Your cooperation is needed to ensure that Black Lung benefits are being received in the correct amount. (1) Failure to provide all or part of the information could prevent an accurate and timely decision as to the beneficiary's continued entitlement. The information you furnish on this form may be used by other agencies or persons in handling matters relating, directly or indirectly, to the subject matter of the claim, including potentially liable coal mine operators and their insurance carriers; medical professionals in obtaining medical services or evaluations; contractors providing automated data processing services to the Department of Labor; representatives of the parties to the claim; and federal state or local agencies in obtaining information about eligibility for benefits. (2) 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. (3) This information is included in Systems of Records, DOL/OWCP-2, DOL/OWCP-9, published at 81 Federal Register 25765, 25858, 25866 (April 29, 2016), or as updated and republished.

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.

NOTICE

If you have a substantially limiting physical or mental impairment, federal disability nondiscrimination law gives you the right to receive help from OWCP 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 the claims examiner to ask about this assistance.

U.S. DEPARTMENT OF LABOR
OWCP/DCMWC
200 Constitution Ave. NW
Washington, DC 20210

Report of Changes That May Affect Your Black Lung Benefits

Department of Labor

OMB No.: 1240-0028
Expires: XX XX XXXX

DOL's Case ID Number: _____

Your Name: _____ Telephone Number: _____

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, provide the new information below, even if your benefits are direct deposit.

_____

_____ _____ _____ Telephone Number: _____

2. List the **name, address and telephone number** of a relative or close friend we can contact, if we are unable to contact you.

Name: _____ Telephone Number: _____

Address: _____

3. Your monthly black lung benefit payment is (Monthly Check Amount): _____

If you also receive BLACK LUNG benefits from another federal or state workers' compensation program, provide the following:

Source: _____ Amount: _____ Frequency of Payment: _____

4. Check the proper box below if your marital status has changed.

- ☐ 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	Date of Death

6. FOR COAL MINERS UNDER AGE 67, 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 beneficiary'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:

TWO FILING OPTIONS:

1. To file electronically, submit completed form and accompanying documentation to the COAL Mine Portal: https://eclaimant.dol-esa.gov/bl
2. To file by mail, use the enclosed envelope to submit completed form and accompanying documentation to:
   U.S. Department of Labor OWCP/DCMWC
   PO Box 8307
   London, KY 40742-8307