

**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: 01-31-2022

Name and Address of Payee (Please Print) Include ZIP  Code Name  Address Line 1  Address Line 2  City  State ZIP  Payee E-mail Address	<b>Distribution copies to:</b> Payee, Operator and Department of Labor <b>Two Filing Options:</b> 1. To file electronically, submit completed form to the COAL Mine Portal: <a href="https://eclaimant.dol.gov/portal/?program_name=BL">https://eclaimant.dol.gov/portal/?program_name=BL</a> . 2. 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 U.S. Department of Labor, Division of Coal Mine Workers' Compensation, 200 Constitution Avenue, Room N-3464, Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**

**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 staff 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.

### **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.

### **Paperwork Reduction Act Statement**

According to the Paperwork Reduction Act of 1995, no person is required to respond to a collection of information unless such collection displays a valid OMB control number.

Collection of this information is authorized by the Black Lung Benefits Act (BLBA), 30 U.S.C. 901 et seq., and 20 CFR 725.621. The obligation to respond to this collection is mandatory/required to obtain or retain benefit. We estimate it takes about 12 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing the collection of information.

Please send comments regarding the burden estimate or any other aspect of this collection of information to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S3323, 200 Constitution Avenue, Washington, DC 20210, or email [suggs.anjanette@dol.gov](mailto:suggs.anjanette@dol.gov), and reference OMB control number 1240-0030.

Note: Please do not return the completed CM-908 application to this address.

