Request for State or Federal Workers' Compensation Information

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

The requested information is needed to process a claim under the Black Lung Benefits Act (30 U.S.C. 901 et. seq.). While completion of this form is voluntary, cooperation is needed in returning this form to determine the claimant's eligibility under the Act. We would appreciate your prompt completion and return of this form.

OMB No. 1240-0032
Expires: 07/31/2023

IDENTIFICATION OF MINER	**(TO BE COMPLETED BY DOL CLAIMS STAFF ONLY)**
To:	1a. Name of Miner (First, Middle, Last)
	b. Date of Birth
	c. Name of Claimant (if different from miner)
	2. Address (Number, street, city, state, Zip code)
3. Employer's Name and Address	4 a. Last Four Digits of Miner's Social Security Number 4.b. DOL's Case ID Number
	5. State or Federal Claim Number(s)
6. Signature of DOL Claims Staff	7. Date (Month, day, year)

II. **WORKERS' COMPENSATION INFORMATION** (To be completed by a State or Federal Workers' Compensation official ONLY)

Please complete all items as appropriate including item 5 if no claim number is provided. Forward the original to the Division of Coal Mine Workers' Compensation and retain a copy in your files for use in notifying the DCMWC of any changes in the beneficiary's workers' compensation status or rate.

8. Has the miner or his/her widow(er) filed a claim for workers' compensation benefits due to pneumoconiosis or other chronic lung disease?

☐ Yes ☐ No (if "Yes", complete items 9,10 and 11, as appropriate.)

9. Status of Claim:

☐ Approved ☐ Denied ☐ Pending

10. Payment Information
a. Date began: _____
b. Expiration Date: _____
c. Weekly Amount $_____
d. Lump sum amount $ _____ representing settlement at $_____ per week for ____ weeks beginning _____
e. Date of Lump sum payment: _____
f. Are medical treatment expenses covered? ☐ Yes ☐ No
g. Date of last exposure _____

11. Were Fees or Expenses paid out of the Award?
a. attorney fees
☐ Yes $ _____ (amount)
☐ No
☐ Unknown

b. Other extraordinary expenses (if "Yes", explain under "Remarks")
☐ Yes $_____. (amount)
☐ No
☐ Unknown

12. Remarks: Please provide a copy of all occupational pneumoconiosis awards; as well as any permanent total life awards, second injury life awards, or settlement agreements. For each permanent total life or second injury award, please provide the award letter, claim decision, and the second injury research sheet.

TWO FILING OPTIONS: 1. To file electronically, submit completed form and accompanying medical documentation to the COAL Mine Portal: https://eclaimant.dol-esa.gov/bl 2. To file by mail, submit completed form and accompanying medical documentation to: US Department of Labor OWCP/DCMWC PO Box 8307 London, KY 40742-8307 For further information call TOLL FREE: 1-800-638-7072.	13. a. Signature and Title	13. b. E-mail Address
	14. Date (Month, day, year)	13. c. Telephone Number:

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time or 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, Room N-3464, 200 Constitution Avenue, N. W., Washington, D.C. 20210. **DO NOT SEND THE COMPLETE FORM TO THIS OFFICE**

Original - Return to DCMWC
Copy - Retain for Status or Rate Change Notification CM-905
Persons are not required to respond to this collection unless it displays a current valid OMB Control Number Rev. 2019

PRIVACY ACT STATEMENT

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. 902(g)) and implementing regulations (20 CFR 725.209, 725.218-219). (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 a System of Records, DOL/OWCP-2, published at 81 Federal Register 25765, 25858 (April 29, 2016), or as updated and republished.

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.