Report of Claims Information for Self-Insured Operators

U.S. Department of Labor
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation
www.dol.gov/owcp/dcmwc/index.htm

OMB No. 1240-0057
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Use this form to report all claims under the Black Lung Benefits Act (BLBA), 30 USC 901-944, as of the date of the report. If you are a new applicant for self-insurance authority, this form must be completed by your current insurance carrier. OWCP will use this information to determine whether you should be authorized (or continue to be authorized) to self-insure your liabilities under the BLBA, and to fix the amount of security you must deposit to guarantee payment of these liabilities. Use of this form is optional; however, furnishing the information is required in order to obtain or retain authority to self-insure under the BLBA. 30 USC 933(a)(1); 20 CFR 726.101-726.115.

1. Parent company's name, address, and EIN

Name: ______________________ City: ______________________

Address: ______________________ State: Zip: ______________

EIN:

2. Reporting Period:

3. Date of this report:

4. Open claims information

Company Name (a)	CASE ID (b)	Last 4 – Miner SSN (c)	Claimant's Name (Last, First) (d)	Claimant's Date of Birth (e)	Claimant's Date of Death (f)	Claim Filing Date (g)	Claim Type (h)	Miner's Name (Last, First) (i)	Miner's Date of Birth (j)	Miner's Date of Death (k)	Miner's Last Date of Employment (l)	Spouse (m)	Spouse DOB (n)	Claim Status/ Most Recent Decision (o)	Date of Most Recent Decision (p)	Hearing or Appeal (q)	Indemnity Benefits Paid During the Reporting Period (r)	Medical Benefits Paid During the Reporting Period (s)	Indemnity Benefits Offset During the Reporting Period (t)	Medical Benefits Offset During the Reporting Period (u)
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5. Contact for questions about report

Name: ______________________ E-mail Address: ______________________ Telephone Number(s):

6. Certification for new applicants

Applicant certification:

I certify that I am an official of the named company duly authorized to file this report, that I have reviewed the information in this report, and that it is accurate to the best of my knowledge.

____

Signature

Name and Title: ______________________ Date: ______________

Insurance carrier certification:

I certify that I am an official of ___[insert current insurance carrier's name]___ duly authorized to provide the information in this report, that I have carefully examined the information in the report, and that the facts reported are true.

____

Signature

Name and Title: ______________________ Date: ______________

7. Certification for currently authorized self-insurers

I certify that I am an official of the named company duly authorized to file this report, that I have carefully examined the information in the report, and the facts reported are true.

____

Signature

Name and Title: ______________________ Date: ______________

PRIVACY ACT NOTICE

In accordance with the Privacy Act of 1974 (5 U.S.C. 552a), as amended, you are hereby notified that: (1) the Black Lung Benefits Act (BLBA)(30 U.S.C. 901 et seq.), as amended, is administered by the Office of Workers' Compensation Programs (OWCP) of the U.S. Department of Labor, which receives and maintains personal information, relative to applications, on claimants and their immediate families;(2) information obtained by OWCP will be used to determine eligibility for benefits payable under the BLBA; (3) information may be given to coal mine operators potentially liable for payment of a claim or to the insurance carrier or other entity which secured the operator's compensation liability; (4) information may be given to physicians or other medical service providers for use in providing treatment, making evaluations and for other purposes relating to the medical management of a claim; (5) information may be given to the Department of Labor's Office of Administrative Law Judges, or other person, board or organization, which is authorized or required to render decisions with respect to a claim or other matters arising in connection with a claim; and (6) information may be given to Federal, state or local agencies for law enforcement purposes, to obtain information relevant to a decision under the BLBA, to determine whether benefits are being or have been paid properly, and where appropriate, to pursue administrative offset and/or debt collection actions required or permitted by law.

Public Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to an information collection unless such collection displays a valid OMB control number. We estimate that it will take an average of 2 hours 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 this burden estimate or any other aspect to this collection of information, including suggestions for reducing this burden, send them to the Division of Coal Mine Workers' Compensation, U.S. Department of Labor, 200 Constitution Avenue, N. W., Suite C3520-DCMWC, Washington, D.C. 20210.

Instructions

You may use this form to report your current BLBA claims information. If you would like to provide this information to OWCP in another format (e.g., a separate spreadsheet), please contact OWCP regarding acceptable alternative formats. For each claim, report the following information. Report all dates in a month/day/year format (e.g., 12/01/2016).

Box 1: Enter the name, address and IRS Employer Identification Number for the company filing the report.

Box 2: Enter the beginning and ending dates for the time period of the reported information.

Box 3: Enter the date the report is completed.

Box 4: Report the information requested for all claims open on the date the report is prepared.

Column (a): Enter the name of the subsidiary liable, or potentially liable, for benefits in the particular claim. If there is no subsidiary, enter the parent company's name.

Column (b): Enter the OWCP case number. This number can be found on any document issued by OWCP in connection with the claim, including the Notice of Claim.

Column (c): Enter the last four digits of the Miner's Social Security Number.

Column (d): Enter the name of the person who filed the claim (the Claimant) in Last Name, First Name format. This may or may not be the Miner.

Column (e): Enter the Claimant's date of birth.

Column (f): If the Claimant is deceased, enter the date of death. If the Claimant is alive, leave blank.

Column (g): Enter the date the Claimant filed his or her claim.

Column (h): Specify the type of claim filed using the following abbreviations:

LM	Miner filed the claim
LW	Miner's surviving spouse or surviving divorced spouse filed the claim
L1	Surviving child filed the claim
P1	Surviving parent filed the claim
S1	Surviving sibling filed the claim
MBO	Medical benefits only claim (i.e., Part B recipient who was awarded medical benefits under Part C)

Column (i): Enter the Miner’s name in Last Name, First Name format.

Column (j): Enter the Miner’s date of birth.

Column (k): If the Miner is deceased, enter the date of death. If the Miner is alive, leave blank.

Column (l): Enter the date of the Miner's last day of employment with the parent or subsidiary listed in Column (a).

Column (m): If the Miner is currently married, enter the spouse's first name and last name if different from the miner's.

Column (n): Enter the spouse's date of birth.

Column (o): Specify the last action taken on the claim using the following abbreviations:

NOC	Notice of Claim and/or Schedule for the Submission of Additional Evidence issued by OWCP, but no decision proposed or entered.
PDOA	Proposed Decision and Order Awarding Benefits issued by OWCP
PDOD	Proposed Decision and Order Denying Benefits issued by OWCP
OALJA	Decision and Order Awarding Benefits issued by ALJ
OALJD	Decision and Order Denying Benefits issued by ALJ
OALJR	Decision and Order Remanding Claim to OWCP issued by ALJ
BRBA	Decision Awarding Benefits (or affirming award) issued by the Benefits Review Board
BRBD	Decision Denying Benefits (or affirming denial) issued by the Benefits Review Board
BRBR	Decision Remanding Claim issued by Benefits Review Board
CAA	Decision Awarding Benefits (or affirming award) issued by Court of Appeals
CAD	Decision Denying Benefits (or affirming denial) issued by Court of Appeals
CAR	Decision Remanding Claim issued by Court of Appeals

Column (p): Enter the date of the most recent decision in the claim. If the claim has not yet been adjudicated by OWCP (i.e., no proposed decision and order has been entered), enter the date of the Notice of Claim.

Column (q): If any party has requested a hearing or filed an appeal after the most recent decision in the claim, check the box in this column. Otherwise, leave it blank.

Column (r): Enter the total amount of indemnity benefits (e.g., disability or survivor's benefits) paid during the reporting period.

Column (s): Enter the total amount of medical benefits paid during the reporting period.

Column (t): Enter the total amount of federal indemnity benefits offset by a state workers' compensation award, earnings offset or federal offset during the reporting period.

Column (u) Enter the total amount of medical benefits offset by a state workers' compensation award.

Box 5: Provide complete contact information for an individual who can answer questions about the report.

Box 6: Certification for new applicants. If you are applying for authority to self-insure, you and your current insurance carrier must both certify the accuracy of the information reported. If you are already authorized to self-insure, skip to box 6. Enter the name and title of each person certifying the report.

Box 7: Certification for authorized self-insurers. Enter the name and title of the person certifying the report.

SUBMISSION INSTRUCTIONS

You may submit this report by e-mail or in hard copy to the following addresses:

E-mail: RO.SELFINSURANCE@DOL.GOV

Hard copy:

United States Department of Labor
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation
Suite C3520-DCMWC
200 Constitution Ave., N.W.
Washington, D.C. 20210
ATTN: Responsible Operator Section

Please contact OWCP's Division of Coal Mine Workers' Compensation (RO Section) at (202) 693-0046 if you have any questions.