



**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:

1. Marriage	7. Change in school attendance of dependent children age 18 or older
2. Divorce	8. Return to work
3. Birth or adoption of dependent child	9. Increased earnings
4. Marriage of dependent child	10. Filing for or receipt of state or other federal workers' compensation benefits
5. Death of spouse/child	
6. Disability of child (any age)	

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 receives 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 NUMBER 1-800-347-2502**

Greensburg, PA  
Charleston, WV  
Denver, CO  
Washington, DC

Johnstown, PA  
Pikeville, KY  
Columbus, OH

### **PRIVACY ACT NOTICE**

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) the Black Lung Benefits Act (BLBA) (30 U.S.C. 901et 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 this application, 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 other government agencies, coal mine operators potentially liable for payment of the claim or to the insurance carrier or other entity which secured the operator's compensation liability, contractors providing automated data processing services to the Department of Labor; and representatives of the parties to the claim; (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 the 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 the claim or other matters arising in connection with the claim; (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; (7) disclosure of the claimant's or deceased miner's Social Security Number (SSN) or tax identifying number (TIN) on this form is voluntary, and the SSN and/or TIN and other information maintained by the OWCP may be used for identification and for other purposes authorized by law; (8) failure to disclose all requested information, may delay the processing of this claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits; and (9) 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.

### **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, 200 Constitution Avenue, N.W., Suite C3520-DCMWC 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.

CM-929 Revised Nov. 2023

U. S. Department of Labor  
 OWCP/DCMWC  
 «DOFADDR2»  
 «DOFCITY», «DOFSTATE» «DOFZIP»  
 «DOFPHONE»



**Report of Changes That May Affect  
 Your Black Lung Benefits**

Department of Labor OMB No. 1240-0028  
 Expires: 05/31/2027

«BENE\_NAME»  
 «BENE\_NAME2»  
 «MAIL\_ADDR1»  
 «MAIL\_ADDR2»  
 «MAIL\_CITY», «MAIL\_STATE» «MAIL\_ZIP»

«LOC» «MASKEDSSN» «BIC» «PART»  
 DOL's Case ID Number: «CASE\_ID»

Your Name: \_\_\_\_\_  
 «BENE\_NAME»

Telephone Number: «PHONE» \_\_\_\_\_

**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.

Check box if no information has changed on form. (Skip to signature box and sign)

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: \_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_ Telephone Number: \_\_\_\_\_

3. Your monthly black lung benefit payment is (Monthly Check Amount): \$[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.

**Do Not Add More Than 3 Beneficiaries to This Section**

**(More Than 3 Beneficiaries Should Be Added to Comments/Additional Information Section)**

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: _____
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**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 have 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 C.O.A.L. Mine Portal: <https://coalmine.dol.gov>
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  
For Further information call TOLL FREE: 1-800-347-2502.