Request To Be Selected As Payee

U. S. Department of Labor
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

I hereby request that the Black Lung benefits for the person or persons named in item (2) below be paid to me. (If you are requesting that your own benefit payments be made directly to you instead of to someone else on your behalf, enter your own name in item 2 and answer the questions on this form with respect to yourself.) Disclosure of the Social Security Number is voluntary. The failure to disclose this number will not result in the denial of any right, benefit or privilege to which you may be entitled.	OMB No.: 1240-0010 Expires: 09/30/2027 **Do Not Write in This Space**
1. Name of coal miner	
2. Name of beneficiary (the person entitled to Black Lung benefits)	DOL's Case ID Number:
3. Your name	

4. What is your relationship to the beneficiary? (If you need more space, attach a separate sheet of paper.)

4a. Why do you wish payment of black lung benefits to be made to you? (If you need more space, attach a separate sheet of paper.)

4b. If benefits are currently direct deposited, do you want them to continue going to the current account? __ Yes __ No. If no, provide:

☐ Checking ☐ Savings

Bank Name __________________________ Account # __________________________ Routing # ________________________

5. Have you ever been convicted of a felony? |___| Yes |___| No If yes, explain below: (If you need more space, attach a separate sheet of paper.)

5a. Do you agree to annual financial reporting and unannounced visits of facilities? ___Yes ___No

Important: Question 6 (page 2) must be answered in all cases. Please review the following list of changes (events) which may affect Black Lung payments and must be reported immediately.

- **Receipt of or change in benefit payments** made under any State Workers' compensation program.
- **Death** of any beneficiary.
- **Marriage** of a person entitled to child's, widow's, parent's, brother's, or sister's benefits.
- **Support payments** received by a person entitled to parent's, brother's, or sister's benefits.
- **Legal adoption** of any entitled child.
- **Stopping of school attendance** by a child, brother, or sister age 18 to 23.
- **Improvement of a disabling condition** of a disabled child, brother, or sister, 18 or older.
- **Work** performed as an employee or a self-employed person, by a miner, parent, brother, or sister.
- **Your conviction of a felony.**

Public Burden Statement

We estimate that it will take an average of 15 minutes 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. The obligation to respond is required to obtain or maintain a benefit. 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 NW, Suite C3520-DCMWC, Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**

TWO FILING OPTIONS:

1. To file electronically, submit completed form to the COAL Mine Portal: https://coalmine.dol.gov
2. **To file by mail, send completed form to:**
   US Department of Labor
   OWCP/DCMWC
   PO Box 8307
   London, KY 40742-8307

For further information call TOLL FREE: 1-800-347-2502

NOTE: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

6. Do you agree to notify the Department of Labor promptly if any event listed occurs, or any other event occurs that might affect the benefits of the person or persons named in item 2? |__| Yes |__| No	7. Do you agree to return promptly any check for benefits received by you if the person or persons named in item 2 is not entitled to it? |__| Yes |__| No
8. Is the person or persons for whom you are asking payment now living with you? |__| Yes |__| No If "No", answer 8a.	8a. Name and address of person with whom he or she is living.
9. Is there a legal representative (guardian, conservator, curator, etc) of beneficiary for whom you are asking payment? |__| Yes |__| No If "Yes," answer 9a. If "No," go on to item 10.	9a. Name and address of the Legal Representative and type of Representative
10. Is the beneficiary under the care of a treating physician? |__| Yes |__| No If "Yes," answer 10a. If "No," go on to item 11.	10a. Name and address of treating Physician
11. Do you understand that all payments made to you on behalf of a beneficiary must be spent for his present needs or (if not presently needed) saved for his future needs and do you agree to use the benefits that way? |__| Yes |__| No	12. Do you agree to notify the Department of Labor promptly if any beneficiary leaves your custody, or when you no longer have responsibility for the welfare and care of any beneficiary for whom you are asking payment? |__| Yes |__| No

PRIVACY ACT STATEMENT

If you misuse benefits received as a representative payee, you may be convicted of a felony and fined under Title 18, U.S.C., or imprisoned for not more than 5 years, or both. The court may also order restitution. 42 U.S.C. 408, incorporated by 30 U.S.C. 923(b), 940.

This section must be completed by the applicant requesting to be selected as payee

Signature (First name, middle initial, last name) (Write in ink)	Telephone Number	Date (Month, Day, Year)
Mailing Address (Include your ZIP code)	Social Security Number or Employer Identification Number	
	County	

Witnesses are required ONLY if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant must sign below, giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (No., St., City, State and ZIP Code)	Address (No., St., City, State and ZIP Code)

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.