

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.

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 725.505-513). (2) The purpose of the information is to determine whether the CM 910 applicant is eligible to be selected as the representative payee for a Black Lung beneficiary. Completion of this form is voluntary. Failure to provide the information may result in your not being selected representative payee. (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 your eligibility to be selected as the representative payee for a Black Lung beneficiary. (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.

This section must be completed by the applicant (as opposed to the claimant) requesting to be selected as payee

Your signature (First name, middle initial, last name) (Write in ink)	Your Telephone Number	Date (Month, Day, Year)																													
Mailing Address (Include your ZIP code)	List your Tax Identification Number																														
	Social Security Number <table border="1" data-bbox="888 1377 1494 1415"> <tr> <td></td><td></td><td></td><td></td><td>-</td><td></td><td></td><td></td><td>-</td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table> OR Employer Identification Number <table border="1" data-bbox="888 1421 1494 1461"> <tr> <td></td><td></td><td></td><td></td><td>-</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>						-				-											-									
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1. Signature of Witness	2. Signature of Witness
Address (No., St., City, State and ZIP Code)	Address (No., St., City, State and ZIP Code)

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.

