OPERATOR RESPONSE TO NOTICE OF CLAIM

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

Miner's Name:	Claimant's Name:	Claim Number: **CASE ID:**	OMB No.: 1240-0033 Expires: 10/31/2026

Responsible Operator's Name:	Insurer's Name:	Policy No.

This information is authorized by the Black Lung Benefits Act 30 U.S.C. 901 et. Seq., and the regulations of the U.S. Department of Labor governing the administration of such Act (20 CFR 725.408). Please check appropriate boxes and provide requested information. While you are not required to respond, if you fail to do so within 30 days of your receipt of the Notice of Claim you shall not be allowed to contest your liability for the payment of benefits on any of the five specific grounds set forth below in Section B. (20 CFR 725.408). You must send a copy of this response to the claimant by regular mail.

A. Acceptance of Liability

☐ The named potentially liable operator is the responsible operator within the meaning of the Black Lung Benefits Act

B. Controversion of Liability

Indicate whether the named potentially liable operator accepts or denies the assertions that follows.
Acceptance of these assertions is not necessarily an acceptance of liability. You may still contest your liability on any other available grounds.

Accepts	Denies	
☐	☐	This operator was an operator for any period after 06/30/73.
☐	☐	This operator employed the miner as a miner for a cumulative period of not less than one year.
☐	☐	The miner was exposed to coal mine dust while working for this operator.
☐	☐	The miner's employment with this operator included at least one working day after December 31, 1969.
☐	☐	This operator or its insurer is financially capable of assuming liability for the payment of benefits.

Time period for submission of evidence. Within 90 days of the date on which you received the Notice of Claim, you may submit documentary evidence in support of your positions asserted in Section B. For any of the assertions you denied, you must submit all relevant documentary evidence within this 90-day period. The time period may be extended for good cause shown if an extension request is filed with the district director prior to expiration of the 90 days period. You must include a statement of reasons why you need additional time with your extension request.

Two Filing Options:

1.To file electronically, submit completed form to the COAL Mine Portal:
https://coalmine.dol.gov

2. To file by mail, submit completed form to:
OWCP/DCMWC/CMR Correspondence
PO Box 8307
London, KY 40742-8307
For Further Information call TOLL FREE: 1-800-347-2502

Privacy Act Statement

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. 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 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

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for 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, 200 Constitution Avenue, N.W., Suite C3520-DCMWC, Washington, D.C. 20210. **Note**: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. (DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.)

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.

C. Additional Information

Please answer the questions below. If the space provided for any response is inadequate, please continue your response on a blank sheet of paper and attach it to the form. If you are unable to respond to these questions within the 30-day period for accepting or denying the assertions set forth in Section B above (*i.e.* within 30 days of receipt of the Notice of Claim), you should return this form in compliance with the 30-day time limitation and provide the information requested in this section within 90 days of your receipt of the Notice of Claim.

1. The miner was employed by the named potentially liable operator (list <u>all</u> periods of employment):

From: _____ To: _____

_____ _____

_____ _____

Miner's Job Classification(s)/ Type(s) of Work Performed	Time Performed (Beginning and Ending Dates)	Name and Location of Mine or Facility (County and State)

2. Our records indicate that the potentially liable operator is insured as indicated in the header of page 1. If this information is incorrect, please complete information below.

Insurance Carrier(s)	Policy Number	Dates of Coverage

3. Is the named potentially liable operator affiliated in any way with any of the other firms identified in the Notice of Claim as potentially liable operators? ☐ Yes ☐ No If yes, please explain the nature of the relationship.

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4. Has the named potentially responsible operator transferred or sold its mine, mines, or coal mining business, or substantially all of the assets thereof, to another person or business organization? ☐ Yes ☐ No If yes, please explain the details of the transaction(s), including the name(s) of the person(s) or organization(s) acquiring the property.

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5. Please set forth any additional facts regarding potential liability you would like to have considered.

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Name and Address of Firm Completing Form	Name of Person Completing Form	
	Title	
	Signature	Date