# Miner's Claim For Benefits Under The Black Lung Benefits Act

**U.S. Department of Labor**
Office of Workers' Compensation Programs

Reset Print

I hereby claim all benefits which may be payable to me under the Black Lung Benefits Act. I also hereby apply on behalf of my family for any benefits that may be payable under the Act.

OMB No. 1240-0038
Expires: 10/31/2014

**IMPORTANT:** No benefits may be paid under the Black Lung Benefits Act, unless a completed application form has been received. However, disclosure of your Social Security Number is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled. Collection of the information on this form is authorized by law (30 U.S.C. 901, et. seq.). This information is required to obtain a benefit.

**(FOR DOL USE)**

1. Miner's full name (First, middle, last)
   First Name | M.I. | Last Name

2. Miner's Social Security Number

3. Miner's date of birth (Month, day, year)

4. Highest grade miner completed in school

5. Have you (or someone on your behalf) ever filed a claim for Federal Black Lung benefits before?
   ☐ Yes ☐ No

6. Decision made (If more than one claim filed, identify and show disposition of each in item 18, "Remarks")
   ☐ Allowed ☐ Denied
   ☐ Withdrawn ☐ Pending

7. Are you still working in or around coal mines?
   ☐ Yes — If "yes," answer only c.
   ☐ No — If "no," answer a-c.

a. When did you stop working in or around coal mines or a coal preparation facility in the extraction, transportation or preparation of coal, or in coal mine construction or maintenance in or around a coal mine?

b. Why did you stop working in or around coal mines or in a coal preparation facility in the extraction, transportation or preparation of coal, or in coal mine construction or maintenance in or around a coal mine?

c. Have you ever been transferred from your regular coal mine job to lighter duty?
   ☐ Yes ☐ No
   if "yes," provide date and reasons why you were transferred. Use space in item 18, "Remarks".

8. How many years have you worked in or around coal mines, or in a coal preparation facility in the extraction or preparation of coal, or worked in coal mine construction or transportation in or around a coal mine?_____ To the best of your knowledge list your complete coal mine Employment History on Form CM-91 1 a.

**NOTE:** If available evidence is not sufficient to arrive at a determination, you may be requested to have an independent medical examination at no expense to you. Should the Department of Labor obtain information useful to your physician for treatment, such information may be furnished to that physician.

9. Describe briefly any disability you believe you have due to pneumoconiosis (Black Lung) or other respiratory or pulmonary disease resulting from coal mine employment. Specifically, what aspect(s) of your regular job in the coal mines are you physically unable to perform as a result of your disability?

**NOTE:** The amount of any state or Federal Workers' Compensation/Occupational Disease benefits you are receiving based on your disability due to coal workers' pneumoconiosis will be subtracted from your benefits under Part C of the Black Lung Benefits Act.

10. Have you filed a workers' compensation claim under any state or Federal law on account of your disability, due to coal workers' pneumoconiosis?

☐ Yes ☐ No (if "yes," complete items a through j).

| a. With what State or Federal agency was the claim filed? | b. Approximate date of filing: | c. Claim No. (if known): |
|---|---|---|
| | | |

| d. Decision made | e. Employer against whom Workers' Compensation Claim was filed? |
|---|---|
| ☐ Allowed ☐ Denied ☐ Pending | |

| f. Amount of payment: | g. Date payment began: |
|---|---|
| Weekly: $ _____ per week<br>Other: $ _____ per _____ | Date payment ended: |

| h. Did you pay any attorney's fees or legal fees in securing your workers' compensation award? | i. If you have received a lump-sum payment based on you compensation claim, please indicate the following: |
|---|---|
| ☐ Yes ☐ No | Period covered (fill in below): Amount: $<br>From: To: |

j. Do you receive any medical treatment benefits as part of your Workers' Compensation benefits? ☐ Yes ☐ No

NOTE- The amount of your earnings, either as an employee or from self-employment, will help us to determine the correct amount of black lung benefits to which you may be entitled. This information is required by the 1981 Amendment to the Black Lung Benefits Act.

11 a. Enter the names and addresses of all persons, companies, or government agencies for which you worked during the previous calendar year. If self-employed, so indicate.

| Name and Address of Employer | Work Began Month, Year | Work Ended Month, Year | Approximate Earnings |
|---|---|---|---|
| name:<br>line 1: city:<br>line 2: state: zip: | | | |

b. How much do you expect your total earnings to be this year? (Count all of your earnings beginning with the first of the year and all expected earnings through the end of this year.) $ _____

| 12. Are you married now? ☐ Yes ☐ No (if "Yes" Complete items a-f.) (if "No" go to item 13). | a. Date of marriage |
|---|---|
| | |

| b. Your spouse's first and maiden name (Print)<br>First Name Maiden Name<br>SSN: | c. Spouse's birth date | d. **Do you and your spouse live together?**<br>☐ Yes ☐ No (**If** "no", answer items e and f) |
|---|---|---|

| e. Are you under a court order to make support payments to your spouse? | f . Do you make regular support payments to your spouse? |
|---|---|
| ☐ Yes ☐ No (if "yes", attach a copy of the order) | ☐ Yes ☐ No (if "yes", indicate amount)<br>$ _____ per _____ (week, month, other) |

13. Were you previously married? ☐ Yes ☐ No (if "yes" answer a through f)

| a. Full Name of your previous spouse:<br>First Name M.I. Last Name | b. Date married (Month, day, year) | c. Place married (City & State) |
|---|---|---|
| | | |
| **d. How marriage ended: (death, divorce)** | **e. Date marriage ended:** | **f. Place marriage ended (City, State)** |
| | | |

If prior marriage ended by divorce and you were married for 10 years before the divorce action, answer questions 14 and 15.

| 14. Are you under a court order to make support payments to a divorced spouse? | 15. D**o** you make substantial contributions to a divorced spouse? |
|---|---|
| ☐ Yes ☐ No (If "yes", attach a copy of the orders) | ☐ Yes ☐ No (if "yes", indicate amount)<br>$ _____ per _____ **(week, month, other)** |

16. Do you have any **Unmarried** children who are:

Under age 18 ☐ Yes ☐ No

Age 18-23 and attending school ☐ Yes ☐ No

Age 18 or older and disabled ☐ Yes ☐ No

**List All Such Children In Order Of Birth Beginning With The Oldest**

**(Use "Remarks' space Item 18 If space below Is insufficient.)**

| | **sex of child** | | **Date of Birth** | Check (X) If **child 18 or over Is student or disabled** | | Check (X) If **that shows child's relationship to you** | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **M** | **F** | **(Mo., day, yr.)** | **STUDENT** | **DISABLED** | **LEGITIMATE** | **ADOPTED** | **STEPCHILD** | **OTHER** |
| Full name of child: / SSN: | ☐ | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Full name of child: / SSN: | ☐ | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Full name of child: / SSN: | ☐ | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Full name of child: / SSN: | ☐ | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**If Any Child Named Above Does Not Live With You, Enter The Name And Address Of The Person Or Organization With Whom The Child Lives in item 18, *Remarks".**

17. The events listed below may affect the amount of your Federal Black Lung Benefits:

your condition improves; or

You become entitled to receive workers' compensation or occupational disease payments due to disability on account of pneumoconiosis; or

The amount of any of the benefits described above to which you are entitled changes; or

You work in or around coal mines or in any other employment, including self-employment.

The events listed below relating to your dependents may also affect the amount of your Federal Black Lung Benefits:

A dependent marries, divorces, dies, or is adopted by someone else; or

A child 18-23 stops attending school, or in the case of a disabled child 18 or older, the disabling condition improves.

It is **IMPORTANT** that you report **PROMPTLY** any of the above events which occur.

Do you agree to notify the Department of Labor if any of the above events occur? ☐ Yes ☐ No

18. Remarks: (You may use this space for any explanations. if you need more space attach a separate sheet.)

19. Do you authorize any physician, hospital, agency, employer or other organization (including the Social Security Administration) to disclose to the Department of Labor any medical records, or Information about your disability or any other information pertinent to your claim?

☐ Yes ☐ No

20. Do you authorize the Department of Labor to give information about the decision on your Black Lung Benefits claim to the Workers' Compensation, Unemployment Compensation, or Disability insurance agency of your State for use in connection with a claim you may have with that agency?

☐ Yes ☐ No

**SIGNATURE OF MINER**

I hereby certify that the information given by me on and in connection with this form is true and correct to the best of my knowledge and belief. I am also fully aware that any person who willfully makes any false or misleading statement or representation for the purpose of obtaining any benefit or payment under this title shall be guilty of a misdemeanor and on conviction thereof shall be punished by a fine of not more than $1,000, or by imprisonment for not more than one year or both.

| 21. Signature of Claimant (First, middle, last) | 22. Date (Month, day, year) |
|---|---|
| | |

| 23. Mailing Address (Number, street, Apt. No., P.O. Box or Rural Route) | 24. City and State |
|---|---|
| | |

| 25. Zip Code | 26. County Where You Now Live | 27. Telephone Number (Include area code) |
|---|---|---|
| | | |

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 address.

| 28. Signature of witness | 29. Signature of witness |
|---|---|
| | |

| 30. Address (Number, street, city, state & zip code) | 31. Address (Number, street, city, state & zip code) |
|---|---|
| city: state: zip: | city: state: zip: |

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

**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. 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, or claimants and their immediate families. (2) information obtained by OWCP will be used to determine eligibility for the amount of benefits payable under the BLBA; (3) information may be given to 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; (4) information may be given to the physicians or 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 Social Security Number (SSN) or tax identifying number (TIN) on this form is voluntary. 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 a reduced level of benefits.

COMPUTER MATCHING PROGRAM: The Department of Labor conducts computer matches with the Department of Health and Human Services and the Department of Veterans Affairs. Any information provided by applicants for and recipients of financial assistance or payments under Federal benefit programs may be subject to verification through computer matches which the Department of Labor conducts with these agencies.

**Public Burden Statement**

Public reporting burden for this collection of information is estimated to average 45 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, Room N-3464, 200 Constitution Avenue, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**