

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, 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.

SIGNATURE OF APPLICANT

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 under 30 USC 941 and, on conviction, subject to a fine of not more than \$1,000.00, or by imprisonment for not more than one year, or both. I authorize any physician, hospital, agency, employer or other organization (including the Social Security Administration) to disclose any medical records, or other information to the Department of Labor, Office of Workers' Compensation Programs. Furthermore, I authorize the Department of Labor, Office of Workers' Compensation Programs to disclose any medical or other information about the decision in your Black Lung Benefits claim to the Workers' Compensation, Unemployment Compensation, or Disability Insurance agency of my State to use in connection with any claim with another agency.

17. Signature in ink (First, Middle, Last)	18. Date
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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.

19. Signature of Witness	20. Signature of Witness
21. Address of Witness	22. Address of Witness
23. City, State, ZIP Code	24. City, State, ZIP Code

Public Burden Statement

Public reporting for this collection of information is estimated to average 8 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 C-3520, 200 Constitution Avenue, NW, Washington, DC 20210. **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 staff to ask for assistance.

TWO FILING OPTIONS:

1. To file electronically, submit the completed form and accompanying documentation to the C.O.A.L. Mine Portal: <https://coalmine.dol.gov>
2. To file by mail submit the completed form and accompanying documentation to:
U.S. Department of Labor OWCP/DCMWC
Central Mail Room
PO Box 8307
London, KY 40742-8307
For further information call TOLL FREE: 1-800-347-2502