Survivor's Form For Benefits Under The Black Lung Benefits Act

Reset Print

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

If you are a survivor of a person who was receiving Federal black lung benefits, this is a Survivor's Notification of the Beneficiary's Death. Otherwise, this is a claim for survivor's benefits. This form is authorized by the Black Lung Benefits Act (30 U.S.C. 901, et seq.) and by 20 C.F.R. 410.221 and 20 C.F.R. 725.304. This information will be used to determine possible eligibility for and the amount of benefits payable under the Act. Benefits may be payable to you, your children and all children of the deceased miner. The information on this form is required to obtain a benefit. However, disclosure of your or the deceased miner's 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. The Department of Labor conducts computer matches with the Social Security Administration. Any information provided by applicants or recipients of financial assistance or payments under Federal benefit programs may be subject to verification through computer matches that the Department of Labor conducts with these agencies.

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Expires: 10/31/2026

(For Agency use only)

1. Deceased Coal Miner's Name: First Middle Last

2. Deceased Coal Miner's Social Security Number:

3. COAL MINER'S BIRTH AND DEATH DATES (ATTACH DEATH CERTIFICATE, IF AVAILABLE)

a. Date of birth:	b. Date of death:	c. Was an autopsy performed? ☐ Yes ☐ No

4. Your name: First Middle Last

5. Your Social Security Number:	6. Your date of birth

7. Mailing Address (Number, Street, Apt. No., PO Box or Rural Route)	8. City, State, & Zip Code

9. Your email address:	10. Telephone Number (Include area code)

11. YOUR RELATIONSHIP TO THE MINER

☐ Surviving Spouse ☐ Dependent Child ☐ Surviving Divorced Spouse ☐ Dependent Parent or Sibling

12. Have you or the miner ever filed a State or Federal workers' compensation claim for death or disability due to coal workers' pneumoconiosis (Black Lung) or any other lung conditions?	☐ Yes	☐ No
13. Have you or any dependent of the miner ever received Federal Black Lung Benefits under **another miner's Social Security number?** If yes, answer a & b.	☐ Yes	☐ No

a. Full Name of other miner for which you received Federal Black Lung benefits?

b. Social Security number of the other miner for which you received Federal Black Lung benefits?

14. Do you or the miner have any dependent unmarried children who are currently under age 18; age 18 to age 23 and attending school; and/or age 18 or older and disabled?	☐ Yes	☐ No
15. Were you or the miner ever married to anyone else?	☐ Yes	☐ No

16. The following events may affect your entitlement to Federal Black Lung Benefits. Do you agree to notify the U.S. Department of Labor promptly if any of the events listed below occur?

☐ Yes ☐ No

- You become entitled to receive any workers' compensation or occupational disease payments because of the miner's disability or death due to pneumoconiosis (Black Lung Disease).
- You or a person receiving benefits marries, dies, or is adopted by someone else.
- You or a person receiving benefits becomes disabled or the existing disability ceases.
- You or a person receiving benefits divorces and/or receives support payments from previous spouse.
- A child (age 18-23) stops attending school, or in the case of the disabled child (age 18 or over), the disabling condition improves.

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, 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

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