

**Request for State or Federal
Workers' Compensation Information**

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



The requested information is needed to process a claim under the Black Lung Benefits Act (30 U.S.C. 901 et. seq.). While completion of this form is voluntary, cooperation is needed in returning this form to determine the claimant's eligibility under the Act. We would appreciate your prompt completion and return of this form.

OMB Control No. 1240-0032
Expiration: 6/30/2026

IDENTIFICATION OF MINER	(TO BE COMPLETED BY DOL CLAIMS STAFF ONLY)	
To:	1a. Name of Miner (First, Middle, Last)	
	b. Date of Birth	
	c. Name of Claimant (if different from miner)	
	2. Address (Number, street, city, state, Zip code)	
3. Employer's Name and Address	4 a. Last Four Digits of Miner's Social Security Number	4.b. DOL's Case ID Number
	5. State or Federal Claim Number(s)	
6. Signature of DOL Claims Staff	7. Date(Month, day, year)	

II. WORKERS' COMPENSATION INFORMATION (To be completed by a State or Federal Workers' Compensation official ONLY)

Please complete all items as appropriate including item 5 if no claim number is provided. Forward the original to the Division of Coal Mine Workers' Compensation and retain a copy in your files for use in notifying the DCMWC of any changes in the beneficiary's workers' compensation status or rate.

8. Has the miner or his/her widow(er) filed a claim for workers' compensation benefits due to pneumoconiosis or other chronic lung disease?

Yes No (if "Yes", complete items 9,10 and 11, as appropriate.)

9. Status of Claim:

Approved Denied Pending

10. Payment Information

a. Date began: _____

b. Expiration Date: _____

c. Weekly Amount \$ _____

d. Lump sum amount \$ _____ representing settlement at \$ _____ per week for _____ weeks beginning _____

e. Date of Lump sum payment: _____

f. Are medical treatment expenses covered? Yes No

g. Date of last exposure _____

11. Were Fees or Expenses paid out of the Award?

a. attorney fees

Yes \$ _____ amount

No

Unknown

b. Other extraordinary expenses (if "Yes", explain under "Remarks")

Yes \$ _____ amount

No

Unknown

12. Remarks: Please provide a copy of all occupational pneumoconiosis awards; as well as any permanent total life awards, second injury life awards, or settlement agreements. For each permanent total life or second injury award, please provide the award letter, claim decision, and the second injury research sheet.

TWO FILING OPTIONS: 1. To file electronically, submit completed form and accompanying medical documentation to the COAL Mine Portal: https://coalmine.dol.gov/ 2. To file by mail, submit completed form and accompanying medical documentation to: U.S. Department of Labor DCMWC Central Mailroom PO Box 8307 London, KY 40742-8307 For further information call TOLL FREE: 1-800-347-2502	13. a. Signature and Title	13. b. E-mail Address
	14. Date (Month, day, year)	13. c. Telephone Number:

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time or reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. This collection of information is required to obtain or retain benefits (30 U.S.C. 901 et seq.). You are not required to respond to this collection unless it displays a current valid OMB Control Number. 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. **DO NOT SEND THE COMPLETE FORM TO THIS OFFICE.**

Original - Return to DCMWC Copy - Retain for Status or Rate Change Notification

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.

NOTICE

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.