

16. Do you have any Unmarried children who are:	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 (Mo., day, yr.)	Check (X) If child 18 or over Is student or disabled		Check (X) If that shows child's relationship to you			
M	F	STUDENT		DISABLED	LEGITIMATE	ADOPTED	STEPCHILD	OTHER	
Under age 18 <input type="checkbox"/> Yes <input type="checkbox"/> No									
Age 18-23 and attending school <input type="checkbox"/> Yes <input type="checkbox"/> No									
Age 18 or older and disabled <input type="checkbox"/> Yes <input type="checkbox"/> No									
Full name of child:	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SSN:									
Full name of child:	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SSN:									
Full name of child:	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SSN:									
Full name of child:	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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, 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.

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.**