U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

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REPRESENTATIVE PAYEE REPORT

INSTRUCTIONS

All representative payees are required to report annually. This is your Representative Payee Report. **You must complete and return the report.** The report will be reviewed by the U.S. Department of Labor and is subject to verification. If you need help completing the report, please contact the office listed above by mail or telephone. THIS REPORT MUST BE COMPLETED AND RETURNED WITHIN 30 DAYS OR BENEFITS MAY BE AFFECTED.

YOUR JOB AS A REPRESENTATIVE PAYEE

Your job as a representative payee is to use the Black Lung benefits you receive for the personal care and well-being of the beneficiary. You must keep yourself informed of the beneficiary's needs so you can decide how the benefits should be used. **You must** notify the U.S. Department of Labor when the beneficiary changes residence or if you no longer exercise responsibility for the care and welfare of the beneficiary. **You must** report the beneficiary's death, marriage, adoption, employment, or release from an institution. **You must** also report the beneficiary's receipt of any State Workers' Compensation Benefits. If the person for whom you receive benefits is a student or is disabled, you must report any changes in school attendance or disability status.

NOTICE

Whoever, having received a payment for the use and benefit of another person, knowingly and willfully uses such payment for other than the use and benefit of the person for whom it is received, is subject to a fine, imprisonment or both.

PAPERWORK/PRIVACY ACT NOTICE

This report is authorized by law (30 USC 922 section 20 CFR 725.523). The information you furnish on this form may be routinely disclosed without your consent to another person or Government agency for purposes such as (1) to comply with Federal laws requiring the release of information from our records; or (2) to conduct research and audit activities needed to assure the continuing integrity and improvement of the U.S. Department of Labor representative payee program. Other routine disclosures of this information are listed in the Federal Register, which will be made available upon request.

PUBLIC BURDEN STATEMENT

We estimate that it will take an average of 10 minutes per response to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the, U.S. Department of Labor, Division of Coal Mine Workers' Compensation, Room C3526, 200 Constitution Avenue, N.W., Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**

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

REPRESENTATIVE PAYEE REPORT

This report is for the period from : _____ to _____	DEPARTMENT OF LABOR USE ONLY
Name and address of representative payee:	Name and address of beneficiary: **Claim Number:**

1. a) Have you lived in the same household as the beneficiary for the whole reporting period?
   b) If no, please explain in the comments section below. [ ] Yes [ ] No

2. How are you related to the beneficiary? (wife, son, daughter, etc . . . .) _____

3. Were all of the beneficiary's benefits, which you received during this reporting period, used or saved for the beneficiary? [ ] Yes [ ] No

4. a) Were benefits spent for the beneficiary on items other than for food, shelter, medical and personal needs? [ ] Yes [ ] No

   b) If yes, briefly explain: _____

COMMENTS (This space is for any comments you may have concerning your position and responsibilities as representative payee):

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE INSTRUCTIONS ON THIS FORM AND THAT THE INFORMATION WHICH I HAVE PROVIDED ON THIS FORM IS TRUE.

SIGNATURE OF PAYEE (If signed by mark (X), two witnesses must sign below)		TELEPHONE NUMBER (Include area code)
	DATE	___ ___ ___ ___ _____ AREA CODE BUSINESS ___ ___ ___ ___ _____ AREA CODE HOME

WITNESS SIGNATURES ARE REQUIRED ONLY IF THE PAYEE'S SIGNATURE ABOVE HAS BEEN SIGNED BY MARK (X)

SIGNATURE OF WITNESS	DATE	SIGNATURE OF WITNESS	DATE