U.S. Department of Labor

Office of Workers' Compensation
Division of Coal Mine Workers' Compensation

Reset Print

REPRESENTATIVE PAYEE REPORT

OMB No.: 1240-0020
Expires: 05/31/2027

INSTRUCTIONS

This is your Representative Payee Report. You are required to file it when the beneficiary dies, when you are no longer serving as the beneficiary's representative payee, or at OWCP's request. 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 call your nearest Black Lung Office at the toll-free 800 number shown in the list below. THIS REPORT MUST BE COMPLETED AND RETURNED WITHIN 30 DAYS.

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

If you misuse benefits received as a representative payee, you may be convicted of a felony and fined under Title 18, U.S.C., or imprisoned for not more than 5 years, or both. The court may also order restitution. 42 U.S.C. 408, incorporated by 30 U.S.C. 923(b), 940.

BLACK LUNG DISTRICT OFFICES TOLL-FREE NUMBER
1-800-347-2502

Greensburg, PA	Johnstown, PA
Charleston, WV	Pikeville, KY
Denver, CO	Columbus, OH

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.

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, 200 Constitution Avenue, N.W., Suite C3520-DCMWC 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.

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 about this assistance.

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:

_____

_____

_____

DOL's Case ID Number: _____

1. Have you lived in the same household as the beneficiary for the whole reporting period? 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) Business Home
RELATIONSHIP TO BENEFICIARY OR TITLE	Date	

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