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

Reset Print

PLEASE KEEP THIS FOR YOUR RECORDS AND FOR FUTURE REFERENCE.

Instructions For CM-929P

Complete, sign, date, and return the enclosed **REPORT OF CHANGES** form within 30 days of receipt. Instructions on how to submit the form online or by mail are on page 5. The form contains information the Department of Labor has concerning the beneficiary's black lung benefits claim. If the information is not correct, please supply the correct information in the spaces provided on the form. Failure to return this form could result in the suspension or termination of benefits.

If you have any questions about this form, please call your nearest black lung office at the toll-free 800-number shown in the list on the following page.

REPORTING REQUIREMENTS

The law requires you to report immediately any of the following events regarding the beneficiary:

1. Marriage
2. Divorce
3. Birth or adoption of dependent child
4. Marriage of dependent child
5. Death of spouse/child
6. Disability of child (any age)
7. Change in school attendance of dependent children age 18 or older
8. Return to work
9. Increased earnings
10. Filing for or receipt of state or other federal workers' compensation benefits

These events could affect the amount of the beneficiary's monthly check. If not reported timely and the beneficiary is overpaid, you may have to pay back the benefits that you incorrectly received. If the information on the form is not correct, you must correct that information.

Your Responsibility 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 contact 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 a hospital or institution. You must also report the beneficiary's receipt of any state workers' compensation benefits and changes in school attendance or disability status, if the person for whom you receive benefits is a student or disabled.

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, or imprisonment or both. Benefits shall be held in an interest bearing account which shows that the money belongs to the beneficiary, i.e., "Your name for beneficiary", "Beneficiary's name by your name", "Your name on behalf of (OBO) beneficiary," etc. If you are not sure whether the account you have established shows this ownership, you should consult your bank and, if necessary, change the account title appropriately.

Representative Payee Reporting Instructions

All representative payees are required to account annually. This is your Representative Payee Report. You must complete and return the report whether you are the beneficiary's relative, friend, or court appointed guardian, or you are an official of a bank or a public or private agency or institution. You should keep a record of the amount of benefits you received and how you used them, because the report will be reviewed by the U. S. Department of Labor and is subject to verification. You will be notified if verification is required. DO NOT submit receipts, canceled checks, etc., with this report. If you need help completing the report, please contact the nearest office listed below. THIS REPORT MUST BE COMPLETED AND RETURNED WITHIN THIRTY DAYS OR BENEFITS MAY BE AFFECTED.

Medical Benefit Information

If the beneficiary is a miner, the Black Lung Disability Trust Fund is responsible for payment of his/her black lung related medical expenses. However, if the beneficiary also receives benefits for a black lung condition from a state or another federal workers' compensation program, the black lung related medical expenses may be paid, partially or totally, by the party who pays those benefits.

Unless another party is responsible for payment of the black lung related medical expenses, the miner should continue to use the Black Lung Identification Card when receiving medical treatment for his/her black lung condition. Examples of black lung related medical services are: hospitalizations, doctor's office visits, medically prescribed drugs, certain types of medical equipment (such as oxygen machines), home nursing services, pulmonary rehabilitation, and the reasonable cost for travel to and from a medical facility for the treatment of the black lung condition.

If you have any questions concerning the medical coverage for the miner's black lung condition, you should contact your Black Lung District Office at the toll free 800 number appearing at the top left corner of page 1.

Computer Matching Program

The Department of Labor will match this information by computer with the Social Security Administration. Any information provided by applicants for and recipients of financial assistance or payments under federal benefits programs may be subject to verification by Department of Labor computer matches with these agencies.

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

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

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. 901et 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 6–80 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 examiner to ask about this assistance.

U.S. DEPARTMENT OF LABOR
OWCP/DCMWC

Report of Changes That May Affect Your Black Lung Benefits

Department of Labor

OMB No.: 1240-0028
Expires: 05/31/2027

DOL's Case ID Number: _____

Claimant's Name: _____

Address: _____ Telephone Number:

_____

IMPORTANT NOTICE: This **ANNUAL REPORT OF CHANGES** must be completed, signed, dated, and returned within thirty (30) days of receipt. Below, you will find information about the beneficiary's federal black lung benefits. If the information is not correct or if you have changes to report, enter the new information in the space provided below each statement or question.

☐ Check box if no information has changed on form for questions 1-6.

1. If you and/or the beneficiary have changed address or telephone number, provide the new information below, even if the benefits are direct deposit.

_____

_____ Telephone Number:

2. List the name and telephone number of a relative or close friend we can contact, if we are unable to contact you.

_____ Telephone Number:

3. The beneficiary's monthly black lung benefit payment is (Monthly Check Amount):

If the beneficiary also receives BLACK LUNG benefits from another federal or state workers' compensation program, provide the following:

Source: _____ Amount: Frequency of Payment: _____

4. Check the proper box below if the beneficiary's marital status has changed.

☐ Death of Spouse - Date of Death _____

☐ Separation from Spouse - Date of Separation _____

☐ Divorce - Date of Divorce _____

☐ Marriage - Date of Marriage _____ Name of Spouse _____

Social Security Number of Spouse:

5. During the last twelve months, if any children who receive FEDERAL BLACK LUNG benefits along with the beneficiary had a change in their condition(s), please provide the following information.

Do Not Add More Than 3 Beneficiaries to This Section
(More Than 3 Beneficiaries Should Be Added to Comments/Additional Information Section)

Child's Name	Date of Birth	Date of Marriage	Date School Attendance Ended	Date Disability Began	Date of Death

Beneficiary-Representative Payee Relationship

6. FOR COAL MINERS UNDER AGE 67, AND DISABELD ADULT CHILDREN, ONLY: If the beneficiary is working and earning money from any type of employment, please give us the following information.

Employer: _____

Total earnings last calendar year:

Estimated earnings for this year:

7. Check below all places the beneficiary lived during the last twelve months.

☐ With you (private residence) – **Go to question 8 below.**

☐ Nursing Home, Personal Care Home, Assisted Living Facility, or any other location – **Go to question 9 (Skip question 8).**

8. **Note: After answering this question, go next to question 19 (skip questions 9 through 18)**

a. Has the beneficiary lived with you for the entire period? If no, please explain under comments below. ☐Yes ☐No

b. How are you related to the beneficiary? _____

c. Were all of the beneficiary's benefits received during this period used or saved for the beneficiary? If no, please explain under comments below. ☐Yes ☐No

d. Were the benefits spent for the beneficiary on items other than food, shelter and personal needs? If yes, please explain below under comments. ☐Yes ☐No

Comments:

9. Give the name and address of each person with whom or each facility where the beneficiary lived during the last twelve months.

Name and Address

Date of residence:

From: _____

To: _____

Name and Address

Date of residence:

From: _____

To: _____

10. How did you find out what the beneficiary's needs were?

11. Do you maintain contact with the beneficiary by:

Letter? ☐Yes ☐No Visit? ☐Yes ☐No Telephone? ☐Yes ☐No E-mail? ☐Yes ☐No

Payee: _____ Type of Claim: _____ DOL's Case ID Number: _____

Black Lung Benefit Accounting

We advised when you were selected as representative payee for the beneficiary, that you are required to account annually for the federal black lung benefits received and spent. Please complete the following questions; do not submit receipts, cancelled checks, etc., with this report. (You will be notified later if verification is required)

Accounting for the Period (Start Date of Accounting Period): _____

To (End Date of Accounting Period): _____

12. Funds on hand from black lung benefits at beginning of this report period: If you have filed a previous U.S. Department of Labor black lung representative payee accounting report, this amount should be the same as the figure shown on your last report (item 17) as remaining balance.

13. **Total black lung benefits received during the reporting period:**

14. Total black lung funds available during this reporting period: (Item 12 plus 13)

15. How available black lung benefits were used during the reporting period:

a. Amount used for beneficiary's food and shelter: (Show in "Remarks" section of this report the name and address of the any person or entity receiving food and shelter payments.)

b. Amount used for beneficiary's clothing:

c. Amount used for beneficiary's medical and dental care:

d. Amount used for personal needs of the beneficiary:

e. Amount used for support of beneficiary's dependents:

f. Amount used for other items: (show purpose for which funds were used in "Comments/Additional Information" section of this report):

16. Total amount used during the reporting period (Add 15a through 15f)

17. Balance remaining at the end of this period. (Item 14 minus Item 16)
If zero, go to Item 20.

18. How is balance of the funds, shown in Item 17, held, saved, or invested?

	Amount	Name(s) that appears on each account.*
Cash:		
Checking Account:		
Insured savings account:		
U.S. Savings Bonds:		
Other (Specify): _____		

* Benefits shall be held in an interest bearing account which shows that the money belongs to the beneficiary, i.e., "Your name for beneficiary", "Beneficiary's name by your name", "Your name on-behalf-of (OBO) beneficiary," etc. If you are not sure whether the account you have established shows this ownership, you should consult your bank and, if necessary, change the account title appropriately.

19. If all benefits received during this reporting period were held, saved, or invested, please explain how the beneficiary's needs were met:

20. During this period, did the beneficiary have any benefits/income other than U.S. Department of Labor Black Lung Benefits?

☐Yes ☐No If "Yes", please indicate the source of the income:

Source: _____ Frequency of Payment: _____ Amount:

Source: _____ Frequency of Payment: _____ Amount:

21. Have you ever been convicted of a felony?

☐Yes ☐No If yes, explain below in remarks section.

Remarks:

22. **This form must be signed and dated.**

I CERTIFY THAT ALL OF THE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. If you conceal or fail to disclose a reporting event with an intent to obtain benefits fraudulently, either in a greater amount or when no payment is authorized, you may be fined, imprisoned, or both, as provided in 30 U.S.C. 941. 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.

Representative Payee's Signature/Mark _____ Date _____

Witness signatures are required only if the payee's signature above has been signed by mark (X).

Witness' Signature _____ Date _____ Witness' Signature _____ Date _____

Comments/Additional Information

TWO FILING OPTIONS:

1. To file electronically, submit completed form and accompanying documentation to the the C.O.A.L. Mine Portal:
   https://coalmine.dol.gov

2. To file by mail, use the enclosed envelope to submit completed form and accompanying documentation to:
   U.S. Department of Labor OWCP/DCMWC
   PO Box 8307
   London, KY 40742-8307

   For further information call TOLL FREE: 1-800-347-2502.