

**DIVISION OF COAL MINE WORKERS' COMPENSATION  
(DCMWC)**

# **C.O.A.L. Mine Portal Guide**



U.S. Department of Labor | Office of Worker's Compensation Programs

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# Claimant Online Access Link (C.O.A.L.) Mine Portal

## Introduction

The claimant Online Access Link (C.O.A.L.) Mine Portal is an electronic document submission system that allows Division of Coal Mine Workers' Compensation (DCMWC) claimants to file a new claim or electronically submit documents to their case file.

**NOTE:** Electronically submitted documents will be available to DCMWC staff immediately after the document upload is complete.

## OWCP Connect (C.O.A.L. Mine Portal) Account Registration

First time users of the C.O.A.L. Mine Portal must create an OWCP Connect account prior to completing or submitting documents to DCMWC. OWCP Connect allows users to prove their identity and create an account for various self-service applications.

1. To begin creating an account, log into <https://coalmine.dol.gov> [C.O.A.L. Mine Portal](#), then click 'File a New Claim'.

2. Select a claim application form to complete. (When submitting the CM-911 or CM-912 we encourage the claimant to complete the CM-911a Employment History form at the same time so it will not delay the process.)

**IMPORTANT NOTE:** Only the claimant can digitally sign these forms. The forms may NOT be signed by an Authorized Representative of the claimant.

3. Next, the claimant will be taken to the account registration page. (Click the 'here' link to create a new account).

The screenshot shows the OWCP Connect website header with the United States Department of Labor logo and the WCS logo. The navigation bar includes links for Login, Account Registration (highlighted with a red box), Reset Password, Change Email, Help, and FAQ. Below the header, there are three main sections: 'About OWCP Connect', 'Account Registration' (highlighted with a red box), and 'Login'. The 'Account Registration' section contains a link 'here' and a warning message: 'WARNING...WARNING...WARNING...WARNING...W'. The 'Login' section has a form for 'Email Address' and a 'LOGIN' button.

4. The claimant will be provided with **2 options** for proving their identity. (Choose one option)

- Identify Proofing Passcode or Questions
- PIV Card – (Government Employee)

The screenshot shows the 'Account Registration' page on the OWCP Connect website. The page title is 'Account Registration' and it includes a sub-section 'Identity Proof Option\*'. There are two radio button options: 'Identity Proofing Passcode or Questions' (selected and highlighted with a red box) and 'PIV' (highlighted with a red box). The 'Identity Proofing Passcode or Questions' option includes a description: 'I want to verify my identity by receiving a text message or voice call with a passcode, or by answering questions about my personal information accessed by credit bureau, and create a new account using a User ID (email address) and a password.' The 'PIV' option includes a description: 'I have Federally-issued PIV card and want to use it to register a new account and login. If you've chosen this option, please insert your PIV card into your card reader before clicking NEXT.' To the right of the registration options is an 'Instructions' section that says: 'Please enter the email address you used to create your account and click NEXT.'

5. Next, enter information in **Required Fields** (identified by an asterisk \*) to create the account.

United States Department of Labor  
Office of Workers' Compensation Programs

WCS  
OWCP Workers' Compensation System

Login | **Account Registration** | Reset Password | Change Email | Help | FAQ

OWCP Connect

### Account Registration

Enter the below information to create the account

First Name*	Jane	Street*	475 L'Enfant Plaza
Last Name*	Doe	City*	Washington
Middle Initial		State*	DC
SSN*	*****	Zipcode*	20024
Date of Birth*	03/20/1968	Primary Phone*	202-222-2222

Check this box if you are able to receive text messages at this phone number

Email\* jane.doe@yahoo.com  
Consider using an email address that is not associated with your current employment.  
[This email is available.](#)

Retype Email\* jane.doe@yahoo.com  
This email is available.

#### Instructions

Please enter the required information and click NEXT to begin the Account Registration process.

NOTE: When entering SSN and Primary Phone, only enter numerical characters. Do not include special characters, like - and (). For example, for the SSN 123-45-6789, you would enter 123456789 in the field.

This information is necessary to access personal Credit Bureau data for purposes of Identity Verification. All data transactions are secure and private.

At this time OWCP Connect is only being used to authenticate new users to FECA's Claimant Query System. You must have an existing OWCP Case Number to access FECA's CQS.

Enter result of addition from image below\*

2+3

5

**NOTE:** If the claimant would like to receive text messages, they must check the box underneath their primary phone number when registering the account.

## Credit Bureau Questions

6. Answer the provided **'Security Questions'** which will be used to validate the claimant's identity.

**United States Department of Labor**  
**Office of Workers' Compensation Programs**

**WCS**  
OWCP Workers' Compensation System

Login | [Account Registration](#) | Reset Password | Change Email | Help | FAQ

### OWCP Connect

This process requires the validation of your identity. Please provide answers to the questions below.

**Which of these phone numbers have you ever used previously?**

- 8132000733
- 8137335581
- 8137849842
- 8138511165
- None of the Above

**Approximately how tall are you?**

- 6'1"
- 6'2"
- 6'4"
- 6'8"
- None of the Above

**In 2013 what county did you live in?**

- Crook
- Fremont
- Goshen
- Lincoln
- None of the Above

\* Required Field

### Instructions

Please complete the personal data verification questions and click NEXT.

This information is generated from Credit Bureau data accessed via the identity information entered on the previous screen.

7. Once the claimant's identity has been verified, they will be prompted to **enter a password** to create an account.

8. Next, the claimant will be prompted to choose a **Security Image** and enter a **Key Phrase**. Both will be used during the login process to confirm the claimant has accessed their account.

**NOTE:** The Key Phrase can be anything, ensure that this phrase is something you can remember. (E.g., Security Image & Key Phrase are both pizza).

9. Next, select **security questions and answers**. (They may be used during the login process for verification).

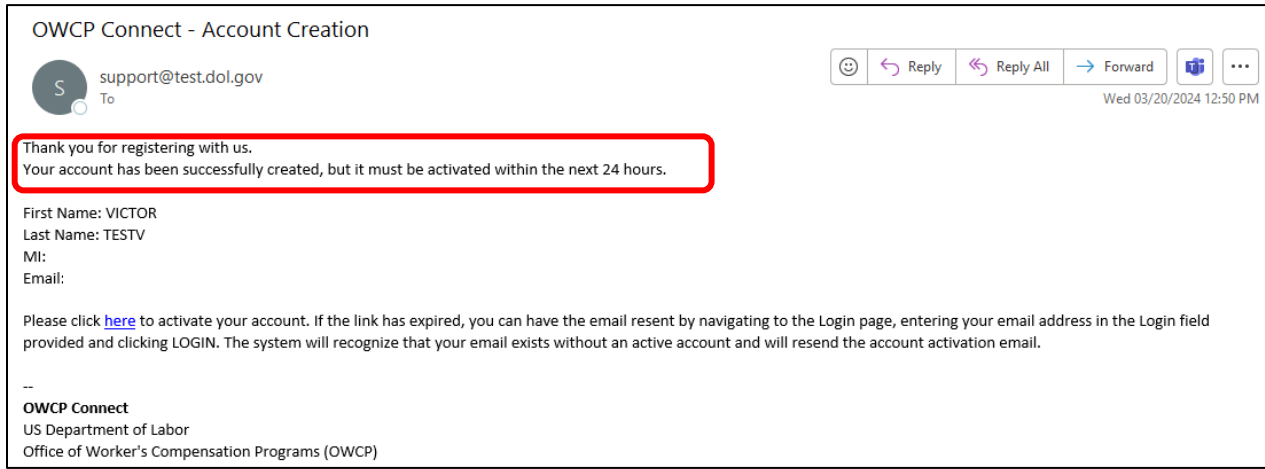
The screenshot shows the OWCP Connect interface. At the top, there is a blue header with the United States Department of Labor Office of Workers' Compensation Programs logo on the left and the WCS logo on the right. Below the header, there is a navigation bar with links for Login, Account Registration, Reset Password, Change Email, Help, and FAQ. The main content area is titled "OWCP Connect" and "Security Questions". A message states: "Please select security questions & answers. They may be used during the login process for login verification." Below this message is a form titled "Security Questions \*" with three questions, each with a dropdown menu and a text input field. The questions are: 1. "What is your maternal grandmother's name?" with the answer "Thomas"; 2. "What was the last name of your childhood best friend?" with the answer "Anderson"; 3. "Who is your favorite actor, musician, or athlete?" with the answer "Berry". A red box highlights the entire form area. Below the form is a note "\* Required Field" and two buttons: "PREV" and "SUBMIT". To the right of the form is an "Instructions" box with the following text: "Please select three security questions, and enter the answers in the spaces provided. These questions and answers may be used to confirm your identity during the login process, and/or if you need to reset your password. When you have selected the questions and entered answers, click SUBMIT."

10. The claimant will now receive a message stating that their account creation request has been submitted successfully.

The screenshot shows the OWCP Connect interface. At the top, there is a blue header with the United States Department of Labor Office of Workers' Compensation Programs logo on the left and the WCS logo on the right. Below the header, there is a navigation bar with links for Login, Account Registration, Reset Password, Change Email, Help, and FAQ. The main content area is titled "OWCP Connect" and "Account Creation". A message states: "Your account creation request has been submitted successfully." Below this message is a red box containing the text: "An email has been sent to the email address you provided, which includes a link that you will need to click in order to activate your account. [The link provided in the email is available for 24 hours.](#)" To the right of the message is an "Instructions" box with the following text: "You will be receiving a confirmation email shortly. You must activate your account by clicking on the link provided in the email."

11. Once the account has been successfully created, the claimant will receive an email notification informing them their account has been successfully created.

**NOTE: The account must be activated within 24 hours.**



12. To log in, enter **Email Address**, then click **Login**.



13. Verify the **security image** and **Key Phrase** then enter **password**.

United States Department of Labor  
Office of Workers' Compensation  
Programs


WCS  
OWCP Workers' Compensation System

Login | Account Registration | Reset Password | Change Email | Help | FA

OWCP Connect

### Login

Welcome **VICTOR TESTV**. Please verify your security image and enter password.

**Security Image** 

**Key Phrase** Pizza

**Password \*** [Masked]

\* Required Field

**SUBMIT**

#### Instructions

Please make sure that the image and key phrase match what you selected and entered when you created your account.

Please enter a new password that meets the criteria listed below, and click **SUBMIT**.

**PASSWORD CRITERIA**

Passwords must be at least 8 characters long, composed of characters from the each of the following four categories:

- Uppercase letters (including, but not limited to A, B, C, Y, Z, etc.)
- Lowercase letters (including, but not limited to a, b, c, y, z, etc.)
- Special Characters (limited to #, ?, !,

**NOTE:** When logging on with a new device, the claimant will have the option of verifying their device by answering a security question, receiving a code via email, or by receiving an SMS verification code to their smartphone.

The claimant will also be given an option to choose whether they would like for the browser to remember their device for future logins so that they can skip this step the next time they log in.

United States Department of Labor  
Office of Workers' Compensation  
Programs

WCS  
OWCP Workers' Compensation System

Login | Account Registration | Reset Password | Change Email | Help | FAC

OWCP Connect

### Login

We do not recognize this device, please answer the security question or enter the verification code.  
Please enter the information requested.

**Security Questions**  
What was the last name of your childhood best friend?  
Anderson

OR  
Click [here](#) to receive a verification code via email.

OR  
Click [here](#) to receive a verification code via SMS.

**Remember this device?**

Yes (The system will remember this device, you can skip this step next time you login from it.)

No

#### Instructions

We don't recognize this device, as this may be your first time logging on. You have the option to either:

1. Enter the answer to the security question you selected when you created your account, OR
2. Click the link provided to receive an email containing a verification code that you can enter here, OR
3. Click the link provided to receive an SMS to your smartphone containing a verification code that you can enter here

Once you have entered the answer to the security question OR the verification code provided via email or SMS, click **SUBMIT** to open the application you selected on the previous screen.

14. Once verification process is complete, the claimant's application will display on screen.

**IMPORTANT NOTE:** The top portion of the form will be auto-filled with claimant information. The claimant **will not** be able to modify any information once the account has been created.

DEPARTMENT OF LABOR  
Office of Workers' Compensation Programs

Start Over | Upload Document | New Claim | Check Status | FAC

Form CM-911

Miner's Claim for Benefits Under  
The Black Lung Benefits Act

U.S. Department of Labor  
Office of Workers' Compensation Programs

I hereby claim all benefits which may be payable to me under the Black Lung Benefits Act. I also hereby apply on behalf of my family for any benefits that may be payable under the Act.

OMB No. 1240-0038  
Expires: 10/31/2026  
(FOR DOL USE)

**IMPORTANT:** No benefits may be paid under the Black Lung Benefits Act unless a completed application form has been received. Disclosure of your Social Security Number is voluntary; the failure to disclose your Social Security number will not result in the denial of any right, benefit, or privilege to which an individual may be entitled. The collection of the other information on this form is authorized by law (30 U.S.C. 901, et. seq.). This information is required to obtain a benefit. The Department of Labor conducts computer matches with the Social Security Administration. Any information provided by applicants or recipients of financial assistance or payments under Federal benefit programs may be subject to verification through computer matches that the Department of Labor conducts with these agencies.

1. Miner's Full Name (First, Middle, Last)  
XAVIER TESTX

2. Miner's Social Security Number  
899010024

3. Mailing Address (Number, Street, Apt. No., P. O. Box or Rural Route)  
2400 XYKEPHONE

4. City, State, & Zip Code  
PORTALND OR 97086

5. Miner's Email Address

6. Telephone Number (Include area code)

7. Miner's Date of birth (Month, day, year)  
03/20/1968

8. Highest grade miner completed in school

Please complete all the items on the form.

If you need help, please call our toll-free number, (800) 347-2502, or email [DCMWC-public@dol.gov](mailto:DCMWC-public@dol.gov).

15. Complete the application, then click **Save & Continue**.

DISABILITY:

NOTE: If available evidence is insufficient to arrive at a determination, you may be requested to have an independent medical examination at no expense to you. Should the Department of Labor obtain information useful to your physician for treatment, such information may be furnished to the physician.

14. Describe briefly any disability you believe you have due to pneumoconiosis (Black Lung) or other respiratory or pulmonary disease resulting from coal mine employment. Specifically, what aspect(s) of your last coal mine employment job in the coal mines are you physically unable to perform as a result of your disability?

CM-911 Rev. (10-2023)

CURRENT EMPLOYMENT AND WAGES:

NOTE: The amount of your earnings, either as an employee or from self-employment, will help us determine the correct payment of black lung benefits to which you may be entitled. This information is required by the 1981 Amendments to the Black Lung Benefits Act.

15. Are you currently working?  Yes  No If yes, answer a.

a. Enter the names and addresses of all persons, companies, or government agencies for which you worked during the previous calendar year. If self-employed, so indicate.

RESET SAVE & CONTINUE

16. Once the application has been completed, review application to ensure all information is correct.


17. The claimant can sign the application now or come back and complete the application and signature later. See next steps for more information.

**NOTE:** Prior to signing application, write down the **Document Control Number (DCN)** from the pop-up screen to be used as a reference.

Form CM-911

Miner's Claim for Benefits Under  
The Black Lung Benefits Act

U.S. Department of Labor  
Office of Workers' Compensation Programs



I hereby claim all benefits which may be payable to me under the Black Lung Benefits Act, including benefits payable to my family.

**IMPORTANT:** No benefits may be paid under the Black Lung Benefits Act unless you disclose your Social Security Number. Disclosure of your Social Security Number is voluntary; the failure to disclose your Social Security Number may result in the denial of any right, benefit, or privilege to which an individual may be entitled under the Act (30 U.S.C. 901, et. seq.). This information is required to obtain benefits from the Social Security Administration. Any information provided to the Social Security Administration may be subject to verification through coal mine health and safety agencies.

1. Miner's Full Name (First, Middle, Last)  
XAVIER

3. Mailing Address (Number, Street, Apt. No., P.O. Box or Rural Route)  
2400 XYKEPHONE

5. Miner's Email Address

7. Miner's Date of birth (Month, day, year)  
03/20/1968

9. Have you (or someone on your behalf) ever filed a claim for Federal benefits before? If yes, answer question 10.  
 Yes  No

11. Are you still engaged in coal mine employment (in or around coal mine construction or maintenance in or around a coal mine)?  
a. When did your coal mine employment end? Provide month, day, and year.

12. In what state of the United States were you working when your coal mine employment ended?

13. How many total years did you work in coal mine employment?

DISABILITY:

### Signature Options

If you choose the "Sign Later" button, you will receive an email (at the address provided) with a link to the document for you to sign at your convenience. Please note that a form can only be processed once it is signed and submitted.

This form has been assigned Document Control Number (DCN) **CC1566**. Please make a note for your records.


## Completing and Signing the Application Form (Now or Later)

To complete and sign the application Now:

### 1. Read the **Electronic Record and Signature Disclosure**.

- Check I agree to use electronic records and signature button.
- Click **Continue**.

### Please Review & Act on These Documents



Office of Workers' Compensation Programs (OWCP)  
eClaimants Portal

Please read the [Electronic Record and Signature Disclosure](#).

 I agree to use electronic records and signatures.

### 2. Click **Start** button to begin signing the application.


DocuSign Envelope ID: B0165CC1-1AE8-49B5-A4E4-39DA5605D1C9

DEMONSTRATION DOCUMENT ONLY  
PROVIDED BY DOCUSIGN ONLINE SIGNING SERVICE  
1915 4th Ave, Suite 1700 • Seattle • Washington 98104 • TEL: 206-439-0200  
www.docuSign.com

**START**

### Miner's Claim for Benefits Under The Black Lung Benefits Act

U.S. Department of Labor  
Office of Workers' Compensation Programs




I hereby claim all benefits which may be payable to me under the Black Lung Benefits Act. I also hereby apply on behalf of my family for any benefits that may be payable under the Act.

OMB No. 1240-0038  
Expires: 10/31/2026  
**(FOR DOL USE)**

**IMPORTANT:** No benefits may be paid under the Black Lung Benefits Act unless a completed application form has been received. Disclosure of your Social Security Number is voluntary; the failure to disclose your Social Security number will not result in the denial of any right, benefit, or privilege to which an individual may be entitled. The collection of the other information on this form is authorized by law (30 U.S.C. 901, et. seq.). This information is required to obtain a benefit. The Department of Labor conducts computer matches with the Social Security Administration. Any information provided by applicants or recipients of financial assistance or payments under Federal benefit programs may be subject to verification through computer matches that the Department of Labor conducts with these agencies.

1. Miner's Full Name (First, Middle, Last) <b>VICTOR</b>	2. Miner's Social Security Number <b>899010022</b>
3. Mailing Address (Number, Street, Apt. No., P.O. Box or Rural Route) <b>2200 VICTORY</b>	4. City, State, & Zip Code <b>Portland OR 97086</b>
5. Miner's Email Address	6. Telephone Number (Include area code)
7. Miner's Date of birth (Month, day, year) <b>05/05/1968</b>	8. Highest grade miner completed in school

3. Click the **Sign** button.

<b>SIGN</b>	<b>SIGNATURE OF MINER</b>	
	<small>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 under 30 USC 941 and, on conviction, subject to a fine of not more than \$1,000.00, or by imprisonment for not more than one year, or both. I authorize any physician, hospital, agency, employer or other organization (including the Social Security Administration) to disclose any medical records, or other information to the Department of Labor, Office of Workers' Compensation Programs. Furthermore, I authorize the Department of Labor, Office of Workers' Compensation Programs to disclose any medical or other information about the decision in your Black Lung Benefits claim to the Workers' Compensation, Unemployment Compensation, or Disability Insurance agency of my State to use in connection with any claim with another agency.</small>	
	24. Signature of Claimant (First, Middle, Last) 	25. Date (Month, Day, Year) 03/20/2024
	<small>Witnesses are required <b>ONLY</b> 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.</small>	
26. Signature of witness	27. Signature of witness	
28. Witness Address (Number, street, city, state & zip code)	29. Witness Address (Number, street, city, state & zip code)	
<small><b>Note:</b> Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.</small>		
<small>Page 3 CM-911 Rev. (10/2023)</small>		

4. **Select Style** for signature.

- Click **Adopt and Sign**.

### Adopt Your Signature

Confirm your name, initials, and signature.

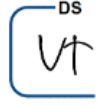
\* Required

**Full Name\***  **Initials\***

**SELECT STYLE**

**PREVIEW** [Change Style](#)

DocuSigned by:



933233D66E61439...

By selecting Adopt and Sign, I agree that the signature and initials will be the electronic representation of my signature and initials for all purposes when I (or my agent) use them on documents, including legally binding contracts.

**ADOPT AND SIGN** CANCEL

5. The claimant's signature will be placed on application.

6. Click **Finish**.


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 under 30 USC 941 and, on conviction, subject to a fine of not more than \$1,000.00, or by imprisonment for not more than one year, or both. I authorize any physician, hospital, agency, employer or other organization (including the Social Security Administration) to disclose any medical records, or other information to the Department of Labor, Office of Workers' Compensation Programs. Furthermore, I authorize the Department of Labor, Office of Workers' Compensation Programs to disclose any medical or other information about the decision in your Black Lung Benefits claim to the Workers' Compensation, Unemployment Compensation, or Disability Insurance agency of my State to use in connection with any claim with another agency.	
24. Signature of Claimant (First, Middle, Last) 	25. Date (Month, Day, Year) 03/20/2024
Witnesses are required <b>ONLY</b> 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.	
26. Signature of witness	27. Signature of witness
28. Witness Address (Number, street, city, state & zip code)	29. Witness Address (Number, street, city, state & zip code)
<b>Note:</b> Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.	
Page 3 CM-911 Rev. (10/2023)	
CM-911 1565.pdf <span style="float: right;">3 of 4</span>	
DocuSign Envelope ID: B0165CC1-1AE8-49B5-A4E4-39DA5605D1C9	
<b>PRIVACY ACT NOTICE</b>	
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	
<b>Ready to Finish?</b>	
You've completed the required fields. Review your work, then select <b>FINISH</b> .	
	


7. The claimant will receive an email notification that the application has been completed.

DocuSign Demo System <dse\_demo@docusign.net>  
To

If there are problems with how this message is displayed, click here to view it in a web browser.

CM-911 1565.pdf  
386 KB

  
Your document has been completed  
[VIEW COMPLETED DOCUMENT](#)

 Office of Workers' Compensation Programs (OWCP)

All parties have completed DCMWC Form CM-911 (DCN CC1565).

To complete and sign the application Later:

1. If the claimant chooses to sign their application form later, upon clicking the 'Sign Later' button, the claimant will be taken back to the home page where they can either select to file another application or exit the C.O.A.L. Mine portal.

**Form CM-911**

**Miner's Claim for Benefits Under The Black Lung Benefits Act**

**U.S. Department of Labor**  
Office of Workers' Compensation Programs

I hereby claim all benefits which may be payable to me under the Act for any benefits that may be payable under the Act.

**IMPORTANT:** No benefits may be paid under the Black Lung Benefits Act unless you disclose your Social Security Number. Disclosure of your Social Security Number is voluntary; the failure to disclose your Social Security Number may result in the denial of any right, benefit, or privilege to which an individual may be entitled under the Act (30 U.S.C. 901, et. seq.). This information is required to obtain benefits under the Social Security Administration. Any information provided to the Social Security Administration may be subject to verification through other Federal benefit programs may be subject to verification through other agencies.

1. Miner's Full Name (First, Middle, Last)  
**XAVIER**

3. Mailing Address (Number, Street, Apt. No., P.O. Box or Rural Route)  
**2400 XYKEPHONE**

5. Miner's Email Address

7. Miner's Date of birth (Month, day, year)  
**03/20/1968**

9. Have you (or someone on your behalf) ever filed a claim for Federal benefits before? If yes, answer question 10.  
 Yes  No

11. Are you still engaged in coal mine employment (in or around coal mines or in coal mine construction or maintenance in or around a coal mine)?  
a. When did your coal mine employment end? Provide month, day, and year.

12. In what state of the United States were you working when your coal mine employment ended?

13. How many total years did you work in coal mine employment?

**Signature Options**

If you choose the "Sign Later" button, you will receive an email (at the address provided) with a link to the document for you to sign at your convenience. Please note that a form can only be processed once it is signed and submitted.

This form has been assigned Document Control Number (DCN) **CC1566**. Please make a note for your records.

**NOTE:** If a claimant chooses to sign the application later, they have the option to go back to the email notification and click on the link to complete the form

2. Once the application has been completed, review application to ensure all information is correct, then click **Save & Continue**.

**NOTE:** Prior to signing application, write down the **Document Control Number (DCN)** from the pop-up screen to be used as a reference.

**DISABILITY:**  
NOTE: If available evidence is insufficient to arrive at a determination, you may be requested to have an independent medical examination at no expense to you. Should the Department of Labor obtain information useful to your physician for treatment, such information may be furnished to the physician.

14. Describe briefly any disability you believe you have due to pneumoconiosis (Black Lung) or other respiratory or pulmonary disease resulting from coal mine employment. Specifically, what aspect(s) of your last coal mine employment job in the coal mines are you physically unable to perform as a result of your disability?

CM-911 Rev. (10-2023)

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**CURRENT EMPLOYMENT AND WAGES:**  
NOTE: The amount of your earnings, either as an employee or from self-employment, will help us determine the correct payment of black lung benefits to which you may be entitled. This information is required by the 1981 Amendments to the Black Lung Benefits Act.

15. Are you currently working?  Yes  No If yes, answer a.  
a. Enter the names and addresses of all persons, companies, or government agencies for which you worked during the previous calendar year. If self-employed, so indicate.

**RESET** **SAVE & CONTINUE**

3. Click Review Document.


DocuSign Demo System <dse\_demo@docusign.net>  
To

If there are problems with how this message is displayed, click here to view it in a web browser.

**DocuSign**

Office of Workers' Compensation Programs (OWCP) sent you a document to review and sign.

**REVIEW DOCUMENT**

 **Office of Workers' Compensation Programs (OWCP)**


VICTOR TESTV,  
**Please DocuSign CM-911 1565.pdf**

Thank You, Office of Workers' Compensation Programs (OWCP)


4. Read the **Electronic Record and Signature Disclosure**.

- Check I agree to use electronic records and signature button.
- Click **Continue**.

## Please Review & Act on These Documents



**Office of Workers' Compensation Programs (OWCP)**  
eClaimants Portal



Please read the [Electronic Record and Signature Disclosure](#).


I agree to use electronic records and signatures.

5. Click the **Start** button to begin signing the application.

START

DocuSign Envelope ID: B0165CC1-1AE8-49B5-A4E4-39DA5605D1C9

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**Miner's Claim for Benefits Under  
The Black Lung Benefits Act**

**U.S. Department of Labor**  
Office of Workers' Compensation Programs


I hereby claim all benefits which may be payable to me under the Black Lung Benefits Act. I also hereby apply on behalf of my family for any benefits that may be payable under the Act.

**IMPORTANT:** No benefits may be paid under the Black Lung Benefits Act unless a completed application form has been received. Disclosure of your Social Security Number is voluntary; the failure to disclose your Social Security number will not result in the denial of any right, benefit, or privilege to which an individual may be entitled. The collection of the other information on this form is authorized by law (30 U.S.C. 901, et. seq.). This information is required to obtain a benefit. The Department of Labor conducts computer matches with the Social Security Administration. Any information provided by applicants or recipients of financial assistance or payments under Federal benefit programs may be subject to verification through computer matches that the Department of Labor conducts with these agencies.

1. Miner's Full Name (First, Middle, Last) <b>VICTOR TESTV</b>		2. Miner's Social Security Number <b>899010022</b>	
3. Mailing Address (Number, Street, Apt. No., P.O. Box or Rural Route) <b>2200 VICTORY</b>		4. City, State, & Zip Code <b>Portland OR 97086</b>	
5. Miner's Email Address		6. Telephone Number (Include area code)	
7. Miner's Date of birth (Month, day, year) <b>05/05/1968</b>		8. Highest grade miner completed in school	

OMB No. 1240-0038  
Expires: 10/31/2026  
**(FOR DOL USE)**

5. Click the **Sign** button.

<b>SIGN</b>	<b>SIGNATURE OF MINER</b>	
	<p>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 under 30 USC 941 and, on conviction, subject to a fine of not more than \$1,000.00, or by imprisonment for not more than one year, or both. I authorize any physician, hospital, agency, employer or other organization (including the Social Security Administration) to disclose any medical records, or other information to the Department of Labor, Office of Workers' Compensation Programs. Furthermore, I authorize the Department of Labor, Office of Workers' Compensation Programs to disclose any medical or other information about the decision in your Black Lung Benefits claim to the Workers' Compensation, Unemployment Compensation, or Disability Insurance agency of my State to use in connection with any claim with another agency.</p>	
	24. Signature of Claimant (First, Middle, Last) 	25. Date (Month, Day, Year) 03/20/2024
	Witnesses are required <b>ONLY</b> 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.	
	26. Signature of witness	27. Signature of witness
	28. Witness Address (Number, street, city, state & zip code)	29. Witness Address (Number, street, city, state & zip code)
	<b>Note:</b> Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.	
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6. **Select Style** for signature.

- Click **Adopt and Sign**.

### Adopt Your Signature

Confirm your name, initials, and signature.

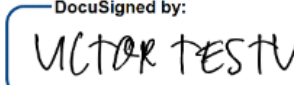

\* Required

**Full Name\***  **Initials\***

**SELECT STYLE**

PREVIEW [Change Style](#)

DocuSigned by:

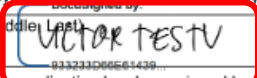

933233D66E61439...

By selecting Adopt and Sign, I agree that the signature and initials will be the electronic representation of my signature and initials for all purposes when I (or my agent) use them on documents, including legally binding contracts.

**ADOPT AND SIGN** CANCEL

7. The claimant's signature will be placed on application.

8. Click **Finish**.

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 under 30 USC 941 and, on conviction, subject to a fine of not more than \$1,000.00, or by imprisonment for not more than one year, or both. I authorize any physician, hospital, agency, employer or other organization (including the Social Security Administration) to disclose any medical records, or other information to the Department of Labor, Office of Workers' Compensation Programs. Furthermore, I authorize the Department of Labor, Office of Workers' Compensation Programs to disclose any medical or other information about the decision in your Black Lung Benefits claim to the Workers' Compensation, Unemployment Compensation, or Disability Insurance agency of my State to use in connection with any claim with another agency.	
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<hr/>	<hr/>
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CM-911 1565.pdf <span style="float: right;">3 of 4</span>	
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<b>PRIVACY ACT NOTICE</b>	
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	
<b>Ready to Finish?</b>	
You've completed the required fields. Review your work, then select <b>FINISH</b> .	
	

9. The claimant will receive email notification that application form has been completed.


DocuSign Demo System <dse\_demo@docusign.net>  
To: [Redacted]

If there are problems with how this message is displayed, click here to view it in a web browser.

CM-911 1565.pdf  
386 KB

**Your document has been completed**

[VIEW COMPLETED DOCUMENT](#)

 **Office of Workers' Compensation Programs (OWCP)**

All parties have completed DCMWC Form CM-911 (DCN CC1565).



[www.dol.gov/owcp/dcmwc](http://www.dol.gov/owcp/dcmwc)

U.S. Department of Labor | Office of Workers' Compensation Programs | Division of  
Coal Mine Workers' Compensation