

INSTRUCTIONS FOR APPLYING OR RENEWING SELF-INSURANCE AUTHORITY UNDER THE BLACK LUNG BENEFITS ACT

The following information and instructions are in accordance with the requirements to self-insure liabilities under the Black Lung Benefits Act (BLBA), 30 USC 901-944. Operators whose prior application for authorization or re-authorization to self-insure is denied may reapply 12 months after a final decision denying such application. To be authorized to self-insure, you must submit a completed “Application or Renewal of Self-Insurance Authority Form” (CM-2017) with the documentation specified below.

New Applicants

You must include the following documents with your initial application:

1. A completed “Report of Claims Information” form (CM-2017b) listing open claims activity for the past year; the information you provide on this form must be certified by your current insurance carrier.
2. A statement from your insurance carrier(s) with the following information:
 - a. the aggregate amount of indemnity benefits paid on approved BLBA claims in each of the prior three years;
 - b. the aggregate amount of medical treatment benefits paid on approved BLBA claims in each of the prior three years.
3. A copy of your most recent, certified actuarial report that outlines both your existing and future projected BLBA liabilities. This report must comply with the standards specified by OWCP, which are posted on the black lung program’s website: <https://www.dol.gov/agencies/owcp/dcmwc/operators-insurers>. The actuarial report you submit may be shared with DOL actuaries for purposes of independent review. OWCP’s self-insurance requirements and other related information is available on the website.

Renewal Applicants

You must include the following documents with your renewal application:

1. A completed “Report of Claims Information” form (CM-2017b) listing open claims activity for the past year.
2. A copy of your most recent, certified actuarial report that outlines both your existing and future projected BLBA liabilities unless you have provided one to OWCP within the past three years. This report must comply with the standards specified by OWCP, which are posted on the black lung program’s website: <https://www.dol.gov/agencies/owcp/dcmwc/operators-insurers>. The actuarial report you submit may be shared with DOL actuaries for purposes of independent review. OWCP’s self-insurance requirements and other related information is available on the website.

INSTRUCTIONS FOR COMPLETING THE APPLICATION FORM

Box 1: Provide the name, address, and IRS Employer Identification Number (FEIN) for the company seeking self-insurance authorization.

Box 2: If the applicant listed in Box 1 is a parent company seeking authorization to self-insure one or more subsidiaries, provide the name, address, and FEIN for each subsidiary.

Box 3: Check all boxes that apply to your business and your subsidiaries' businesses, if any.

Box 4: Provide information about the specific mines and workforce at those mines to be covered by the self-insurance authority.

Column a: Provide the name and address of each mine to be covered under the self-insurance authority.

Column b: If mine sites operate under a subsidiary company of the applicant, provide the subsidiary's name for each mine site.

Column c: Insert the Mine Safety and Health Administration's I.D. number for each listed mine site.

Column d: List the type(s) of mining (i.e., underground, surface, preparation plant work, coal transportation, coal mine construction, mine equipment installation and maintenance) performed at the listed mine site, and the total number of miners employed in each category at the time of this application.

Column e: Estimate the number of employees who would be covered by the BLBA at the time of this application.

Column f: Provide the total payroll amount for employees who would be covered by the BLBA for each of the three years prior to this application.

Box 5: To secure your obligations under the BLBA, indicate the type of security you would prefer to use if authorized to self-insure. Please check all that apply.

Box 6: Indicate how you intend to administer BLBA claims if authorized to self-insure. Please explain how you will administer payment of monthly benefits and medical treatment benefits. If you intend to self-administer claims, explain the qualifications of those individuals who will process claims. If you intend to use a third-party administrator, provide a profile of the organization showing the experience of personnel who would manage BLBA claims and the name, telephone number, and e-mail address of the primary point of contact for claims processing.

Box 7: Provide a claims-information summary for the three years prior to this application. At the top of the second, third, and fourth columns, indicate the year for which the information is provided. For each year, report the following information for the parent company and any subsidiary operations that would be covered by your self-insurance authority:

Row a: Total number of claims in which an award was entered, and you or your insurance carrier accepted liability (i.e., did not request a hearing or file an appeal), excluding any “Medical Benefits Only” claims.

Row b: Medical Benefits Only claims (i.e., claims awarded under Section 11 of the 1977 Black Lung Benefits Reform Act, 30 USC 924a (repealed)) being paid by you or your insurance carrier.

Row c: Number of claims in which you or your insurance carrier challenged an award (i.e., requested a hearing or filed an appeal).

Row d: Number of new claims filed in which OWCP identified you as a potentially liable operator or as the responsible operator.

Row e: Total amount of indemnity benefits you or your insurance carrier paid (i.e., miner's disability benefits and/or survivor's benefits).

Row f: Total amount of medical benefits you or your insurance carrier paid.

Box 8: If the applicant is a corporation, provide the date of incorporation; otherwise, leave the box blank.

Box 9: If the applicant is a corporation, provide the state of incorporation. The state of incorporation is the state in which the business's articles of incorporation are filed, not necessarily the state where the mine or office is located; otherwise, leave the box blank.

Box 10: If the applicant is not a corporation, provide the date the applicant was established in business; otherwise, leave the box blank.

Box 11: If the applicant is a successor to another coal mine operator (e.g., purchased the majority of the mining assets of another operator), check the “yes” box and provide all details of the transaction, including the name of the prior operator and the date of the transaction; otherwise, check the “no” box.

Box 12: If the applicant's business or corporate structure has changed at any point in the three years before this application, check the “yes” box and describe the structural change; otherwise, check the “no” box.

Boxes 13-16: Provide the names of your principal officers.

Box 17: Provide the name, telephone number, and e-mail address for the applicant's Risk Manager.

Boxes 18-20: An official of the applicant, duly authorized to certify the facts in the application and attachments, must sign and date the application.

SUBMISSION INSTRUCTIONS

You may submit the application and attachments by e-mail or by postal mail to:

E-mail: RO.SELFINSURANCE@dol.gov

Hard copy: United States Department of Labor
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation
200 Constitution Ave., N.W.
Suite C3520-DCMWC
Washington, D.C. 20210
ATTN: R.O. SECTION

Please contact OWCP's Division of Coal Mine Workers' Compensation's Responsible Operator Section at (202) 693-0046 should you have any questions. For immediate attention, please E-mail us at RO.SELFINSURANCE@dol.gov.