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: 05/31/2024

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 OFFICE TOLL-FREE NUMBERS

Greensburg, PA	800-347-3753	Johnstown, PA	800-347-3754
Charleston, WV	800-347-3749	Parkersburg, WV	800-347-3751
Mt. Sterling, KY	800-366-4628	Pikeville, KY	800-366-4599
Denver, CO	800-366-4612	Columbus, OH	800-347-3771

PRIVACY ACT NOTICE

The following statement is made in accordance with the Privacy Act of 1974, 5 U.S.C. 552a. (1) Submission of this information is required by law (30 U.S.C. 922, and 20 CFR 725.513). (2) The information you furnish on this form may be used by other Government agencies or persons in handling matters relating, directly or indirectly, to the subject matter of the claim including potentially liable coal mine operators and their insurance carriers; contractors providing automated data processing services to the Department of Labor; representatives of the parties to the claim; and federal, state or local agencies in obtaining information about eligibility for benefits. (3) The Information may be disclosed to comply with Federal laws requiring the release of information from our records; or to conduct research and audit activities needed to assure the continuing integrity and improvement of the U.S. Department of Labor representative payee program. (4) 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, Room N-3464, 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.

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 : 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)
RELATIONSHIP TO BENEFICIARY OR TITLE	Date	Business 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