# Request To Be Selected As Payee

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

I hereby request that the Black Lung benefits for the person or persons named in item (2) below be paid to me. (If you are requesting that your own benefit payments be made directly to you instead of to someone else on your behalf, enter your own name in item 2 and answer the questions on this form with respect to yourself.) Disclosure of the Social Security Number is voluntary. The failure to disclose this number will not result in the denial of any right, benefit or privilege to which you may be entitled.

OMB No.: 1240-0010
Expires: 05-31-2015

Do Not Write In This Space

**1.** Name of Coal Miner

Claim Number/SSN

**2.** Name of beneficiary (the person entitled to Black Lung benefits)

Social Security Number

**3.** Your name

**4a.** What is your relationship to the beneficiary? (if you need more space, attach a separate sheet of paper.)

**4b.** Why do you wish payment of Black Lung benefits to be made to you? (If you need more space, attach a separate sheet of paper.)

**5.** Have you ever been convicted of a felony?

If yes, explain below: (if you need more space, attach a separate sheet of paper.)

**Important:** Question 6 (page 2) must be answered in all cases. Please review the following list of changes (events) which may affect Black Lung payments and must be reported immediately.

- **Receipt of or change in benefit payments** made under any state Workers' Compensation program.
- **Death** of any beneficiary.
- **Marriage** of a person entitled to child's, widow's, parent's, brother's, or sister's benefits.
- **Support payments** received by a person entitled to parent's, brother's or sister's benefits.
- **Legal adoption** of any entitled child.
- **Stopping of school attendance** by a child, brother, or sister age 18 to 23.
- **Improvement of a disabling condition** of a disabled child, brother, or sister, 18 or older.
- **Work** performed as an employee or a self-employed person, by a miner, parent, brother, or sister.
- **Your** conviction of a felony.

## Public Burden Statement

We estimate that it will take an average of 15 minutes 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. The obligation to respond is required to obtain or maintain a benefit. 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 N3464, 200 Constitution Avenue, N.W., Washington, DC 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.

6. Do you agree to notify the Department of Labor promptly if any event listed occurs, or any other event occurs that might affect the benefits of the person or persons named in item 2?

7. Do you agree to return promptly any check for benefits received by you if the person or persons named in item 2 is not entitled to it?

**8a.** Is the person or persons for whom you are asking payment now living with you?

If "No," answer 8 b. and 8 c..

**8 b.** Name of person not living with you.

**8 c.** Name and address of person with whom he or she is living.

City

State Zip

**9a.** Is there a legal representative (guardian, conservator, curator, etc.) of any benefici--ary for whom you are asking payment?

If "Yes," answer 9 b. If "No," go on to item 10.

**9 b.** Name and address of the Legal Representative and type of Representative

City

State Zip

**10a.** Is the beneficiary under the care of a treating physician?

If "Yes," answer 10 b. If "No," go on to item 11.

**10 b.** Name and address of Treating Physician

City

State Zip

**11.** Do you understand that all payments made to you on behalf of a beneficiary must be spent for his present needs or (if not presently needed) saved for his future needs and do you agree to use the benefits that way?

**12.** Do you agree to notify the Department of Labor promptly if any beneficiary leaves your custody, or when you no longer have responsibility for the welfare and care of any beneficiary for whom you are asking payment?

## PRIVACY ACT STATEMENT

Section 901 of Title 30 to the US Code and 20 CFR 725.504 - 513 authorize collection of this information. The purpose of this information is to determine whether the CM-910 applicant is eligible to be selected as the representative payee for a black lung beneficiary. Completion of this form is not mandatory; however, failure to provide the information may result in your not being selected as a representative payee. Additional disclosures of this information may be to: coal mine operators, who may be liable for benefit payments, as well as their insurers and legal representatives; state workers' compensation agencies or the Social Security Administration, for the purpose of determining benefit payment offsets as specified under the Black Lung Benefits Act; the Internal Revenue Service and other federal, state and local agencies for the purpose of conducting investigations related to the proper payment of benefits; labor unions of which the beneficiary is a member for the purpose of exercising an interest in the Black Lung claim of its members as a part of their service to the members, data processing contractors to the U. S. Department of Labor and debt collection agencies and credit bureaus for the purpose of collecting overpayments that might be made to the beneficiary.

**The penalty upon conviction for the misuse of benefits by a representative payee is a felony and/or imprisonment for up to five (5) years for the first offense, pursuant to Public Law 98-460, 42 U.S.C. 408. A second offense is punishable by up to five (5) years of imprisonment and/or a fine not exceeding $25,000. The court may also order restitution.**

### Signature Of Applicant

Signature (First name, middle initial, last name) (Write in ink)

Telephone Number

Date (Month, Day, Year)

Mailing Address (include your ZIP Code)

City

State Zip

Social Security Number

County

**Witnesses are required ONLY 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 addresses.**

1. Signature of Witness

Address (No., St., City, State and ZIP Code)

City State Zip

2. Signature of Witness

Address (No., St., City, State and ZIP Code)

City State Zip