

State of Montana
Department of Labor & Industry
Steve Bullock, Governor



Employment Relations Division _____

WC Regulation Bureau
Administration _____

**BEFORE THE EMPLOYMENT RELATIONS DIVISION
OF THE MONTANA DEPARTMENT OF LABOR AND INDUSTRY**

APPLICATION FOR SILICOSIS BENEFITS

Instructions: This form is to be used for persons applying for silicosis benefit payments under the Silicosis Benefit Program under Section 39-73-105, MCA. In order to be eligible for such payments, a person must: (1) Have silicosis resulting in total disability, rendering it impossible to continuously follow any substantial gainful manual occupation; (2) Not have a salary exceeding \$150 per month; (3) Have resided in and been an inhabitant of Montana for at least ten consecutive years immediately preceding the date of application; and (4) Not be receiving full benefits under the Montana Occupational Disease Act.

I, _____, **HEREBY MAKE APPLICATION FOR SILICOSIS BENEFITS.**

Date of Birth: _____ **SSN:** _____.

I HAVE RESIDED IN MONTANA FOR THE PAST TEN (10) CONSECUTIVE YEARS AT THE FOLLOWING ADDRESSES.

At _____ From _____ To _____
At _____ From _____ To _____
At _____ From _____ To _____

I WAS EXPOSED TO SILICA DUST DURING EMPLOYMENT AS FOLLOWS:

Employer _____ At _____ From _____ To _____
Employer _____ At _____ From _____ To _____

CURRENT EMPLOYER _____ **MONTHLY WAGE** _____

OTHER INCOME SOURCES:

Source _____ Amount _____
Source _____ Amount _____
Source _____ Amount _____

YOUR SPOUSE: NAME _____ **BIRTHDATE** _____

ADDRESS _____

APPLICANT'S SIGNATURE _____ **DATE** _____