United States of America
Railroad Retirement Board

PROPOSED

Form Approved
OMB No. 3220-0164

QUESTIONNAIRE - REINSTATEMENT OF DISCHARGED OR SUSPENDED EMPLOYEE	SOCIAL SECURITY NUMBER
	NAME

The above-named employee is claiming benefits under the Railroad Unemployment Insurance Act. The employee has advised us that you are handling his/her case for reinstatement. In this regard, please answer the questions below and return the letter using the enclosed envelope. Thank you for your cooperation in this matter.

Sincerely,

PAPERWORK REDUCTION ACT NOTICE

This notice is given under the Paperwork Reduction Act of 1995. The Railroad Retirement Board's authority for collecting the information on this form is section 12(l) of the Railroad Unemployment Insurance Act. The information is needed to help determine the claimant's availability for work and whether the claimant received back pay for time lost. Your obligation to provide us with this information is voluntary.

We estimate this form takes an average of 5 minutes per response to complete, including the time for reviewing the instructions, getting the needed data and reviewing the completed form. Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number. If you wish, send comments regarding the accuracy of our estimate or any other aspect of this form, including suggestions for reducing the completion time, to the Chief of Information Resources Management, Railroad Retirement Board, 844 North Rush St. Chicago, IL 60611-2092.

1. Are you currently handling this employee's case for reinstatement? ☐ Yes ☐ No
2. Is pay for time lost being claimed? ☐ Yes ☐ No
3. If you are no longer handling the employee's case for reinstatement, enter the date such efforts were abandoned.

Mo.	Day	Year

4. If reinstatement efforts have been passed on to someone else, enter the following information:

NAME: ____________________

ADDRESS: ____________________

TITLE: ____________________

TELEPHONE: (   ) ____________________

5. If the employee has returned or expects to return to work, enter the date.

Mo.	Day	Year

6. I certify that the information given on this form is true and complete.

SIGNATURE: ____________________ DATE: ____________________

ID-8K (99-99)