United States of America
Railroad Retirement Board

CURRENT

Form Approved
OMB No. 3220-0187

Continuing Disability Report

Paperwork Reduction Act/Privacy Act Notice

The Railroad Retirement Board's (RRB) authority for requesting this information is Section 7(b)(6) of the Railroad Retirement Act (RRA). The information requested on this report is needed to determine your continuing entitlement to disability benefits under the RRA and the correct amount of such benefits. If you fail or refuse to furnish information which is necessary to determine your continuing entitlement to benefits, non-payment of benefits may result (as explained in Section 2(a) of the RRA).

The information on this form may be disclosed by the RRB to another person or governmental agency only with respect to railroad retirement benefits and only to comply with Federal law requiring the exchange of information between the RRB and another agency.

We estimate this form takes an average of 35 minutes 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 completion time, to Chief of Information Resources Management, Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois 60611-2092.

Section 1 General Instructions

Type or print all answers legibly in ink. If you need more space than is provided to answer a question, use Section 6 for this purpose. If you do not know the answer to a question, print "Unknown" in the space provided for the answer.

Due to the complexity of Items 14a and 25a, regarding "Expenses," contact the Railroad Retirement Board if you need assistance.

If you are completing this form on behalf of someone else, you must answer each question as it applies to the applicant.

Some items in this application will not apply to you so you will not need to answer them. Based on your answers to a question, you may be told to skip to another item number or section. Follow the instructions that tell you to "Go to" another item. They are designed to help you move through the report quickly and provide only necessary information. **If no "Go to" instructions are given, answer the next item in order. Do not skip any items unless directed to do so.**

If you are an employee, your annuity cannot be paid for any month in which you earn over $730.00. Please notify the nearest office of the RRB if your earnings exceed $730.00 a month.

THE PERIOD COVERED IN THIS REPORT IS	Month	Day	Year	TO PRESENT

Section 2 Identifying Information

Check the information provided for Items 1 through 5 for accuracy.

- ▶ If the information is correct, **go to Section 3.**
- ▶ If the information is not correct, cross out the incorrect information and enter the correct information above it.
- ▶ If the information is missing, fill it in.

Identifying Information

1 Employee's Name	
2 Employee's Social Security Number	**3** Employee's Railroad Retirement Claim Number
4 Your Name	**5** Your Social Security Number

Section 3 Information about Work for an Employer

Work for Employer

6 Have you worked for an employer (railroad or nonrailroad) during the period shown in Section 1, above? ▶

- ☐ Yes ▶ Go to Item 7
- ☐ No ▶ Go to Section 4

Last Work for Employer

7 Enter information about your employer(s) in Items 7a-c below. (**Note:** If you have had more than one employer during the period covered in this report, enter information about your last employer first.)

a (1) First Employer's Name

(2) Employer's Address

(3) Employer's Telephone Number (Include Area Code)
☎ ( )

(4) Title/Name of your job

(5) Describe your job duties. (Include weights lifted and how frequently lifted; hours spent standing/sitting; frequency of bending/stooping/climbing, etc.)

(6) Monthly Rate of Pay $ _____	**(7)** Days Worked Per Week
(8) Hours Worked Per Day	**(9)** Hourly Rate of Pay $ _____

(10a) Date Work Began ▶	Month	Day	Year	**(10b)** Date Work Ended ▶	Month	Day	Year

(11) If work has ended, explain why.

Second Last Employer

b (1) Second Employer's Name

(2) Employer's Address

(3) Employer's Telephone Number (Include Area Code)
☎ ( )

(4) Title/Name of your job

(5) Describe your job duties. (Include weights lifted and how frequently lifted; hours spent standing/sitting; frequency of bending/stooping/climbing, etc.)

(6) Monthly Rate of Pay $ _____	**(7)** Days Worked Per Week
(8) Hours Worked Per Day	**(9)** Hourly Rate of Pay $ _____

(10a) Date Work Began ▶	Month	Day	Year	**(10b)** Date Work Ended ▶	Month	Day	Year

(11) If work has ended, explain why.

Third Last Employer

7 c (1) Third Employer's Name

(2) Employer's Address

(3) Employer's Telephone Number (Include Area Code)
☎ ( )

(4) Title/Name of your job

(5) Describe your job duties. (Include weights lifted and how frequently lifted; hours spent standing/sitting; frequency of bending/stooping/climbing, etc.)

(6) Monthly Rate of Pay $ _____	**(7)** Days Worked Per Week
(8) Hours Worked Per Day	**(9)** Hourly Rate of Pay $ _____

(10a) Date Work Began ▶	Month	Day	Year	**(10b)** Date Work Ended ▶	Month	Day	Year

(11) If work has ended, explain why.

(If you need more space to list employers, continue in Section 6)

Earnings

8 List any months during the period shown in Section 1, in which you earned more than $730.00.

Special Earnings

9 a Have your earnings included any other payment, such as tips, bonuses, child care, sick or vacation pay, free meals, room or transportation? ▶
- ☐ Yes ▶ Go to Item 9b
- ☐ No ▶ Go to Item 10

b List below type of other payment(s) received, estimated dollar value, frequency of payment, and employer's name.

3 Months or Less Work

10 Did you work 3 months or less and then stop work because of your disabling condition? ▶
- ☐ Yes
- ☐ No

Continue or Return to Work

11 Did you continue in or return to the same work duties, hours, and pay as you had before your disabling conditions began? ▶
- ☐ Yes ▶ Go to Item 14
- ☐ No ▶ Go to Item 12

Special Employment

12 a Are (were) you employed by a friend or relative or through a special training or rehabilitation program? ▶
- ☐ Yes ▶ Go to Item 12b
- ☐ No ▶ Go to Item 13

Special Employment (Continued)

12 b Explain how and why you were hired.

Different Job Duties

13 a Have your job duties differed from those of other workers with the same job title? ▶ ❑ Yes ▶ Go to Item 13b ❑ No ▶ Go to Item 14

b Check all that apply them **go to Item 13c.**

❑ **1.** Shorter hours ❑ **2.** Different pay scales ❑ **3.** Fewer or easier duties
❑ **4.** Extra help given ❑ **5.** Lower production ❑ **6.** Lower quality
❑ **7.** Other - Explain in Item 13c

c Explain in more detail, each selection made in Item 13b. **Note:** For each explanation, include the item number at the beginning of the answer. Also, if you have had more than 1 employer, identify the employer after each explanation.

Impairment–Related Expenses

14 a Do you have any impairment–related expenses that are necessary for you to work? (For example, prescription medications, medical services, attendant care, medical devices, equipment, prosthesis, or similar items or services.) ▶ ❑ Yes ▶ Go to Item 14b ❑ No ▶ Go to Section 4

b List each impairment-related expense and provide a receipt.

Section 4 Information about Self-Employment

Only complete Section 4 if you were self-employed during the period shown in Section 1. Otherwise, **go to Section 5.**

Self-Employment

15 a Enter the name and address of your business.

b Did you work 40 or more hours a month? ▶ ❑ Yes ❑ No

c Check the box that describes the nature of the business. ▶ ❑ Farm ❑ Non-Farm

d Enter the primary product or service.

e Check the box that describes the business in terms of arrangement and/or ownership. ▶ ❑ Sole Owner ❑ Partnership ❑ Farm Tenant ❑ Farm Landlord

f Enter, below, the requested information about your monthly self-employment income for each month during the period shown in Section 1, starting with the latest month. If you need more space, continue in Section 6 or attach a separate piece of paper.

Month	Year	Hours Worked in Month	Gross Income	Net Income

g Prior to the period shown in Section 1, what did you do in the business in terms of management decisions, responsibilities, hours, production and services?

h Was this business your sole livelihood before the period shown in Section 1? ▶ ❑ Yes ❑ No

Self-Employment (Continued)

15 i Describe the duties you perform on an average work day. Include any changes in your business because of your disabling condition, such as reduced business hours, lower volume, fewer acres under cultivation, etc.

Assistants

16 a Because of your disabling condition, do you need additional help to perform your usual duties? ▶ ❑ Yes ▶ Go to Item 16b ❑ No ▶ Go to Item 17

b Enter the number of assistants you have.

c Check the box that describes when you receive assistance. ▶ ❑ By the day ❑ By the week ❑ By the month

d Enter how many hours your assistant(s) spends helping you? (Show if per day, week, or month.)

e Describe what your assistant(s) does to help you.

Assistants (Continued)

16 f Does your assistant(s) get paid? ▶ ❑ Yes ▶ Go to Item 16g ❑ No ▶ Go to Item 16h

g Enter the amount your assistant(s) gets paid. (Show if per hour, day, or month.)

h Is your assistant(s) related to you? ▶ ❑ Yes ▶ Go to Item 16i ❑ No ▶ Go to Item 16j

i Enter the relationship of your assistant(s) to you.

j Explain why you need additional help.

Decisions

17 a Have you made management decisions during the period shown in Section 1? ▶ ❑ Yes ▶ Go to Item 17b ❑ No ▶ Go to Item 18

b Describe the type of management decisions you made, how much time you spent making them, and any changes that have taken place.

Business Began	**18** Did you start your business after your disabling condition began?	▶	❑ Yes ▶ Go to Item 19 ❑ No ▶ Go to Section 5
	19 Did you receive any special assistance from an agency or other source in setting up your business?	▶	❑ Yes ▶ Go to Item 20 ❑ No ▶ Go to Item 22
	20 Do you still receive this special assistance or have additional special services been supplied?	▶	❑ Yes ▶ Go to Item 21 ❑ No ▶ Go to Item 22
	21 Describe the continued assistance or special services.		
Business Expenses	**22** Are there any normal business expenses paid for or furnished by another person or organization (for example, free space or utilities)?	▶	❑ Yes ▶ Go to Item 23 ❑ No ▶ Go to Section 5
	23 List the business expenses paid for or furnished, and provide the dollar value.		
	24 Explain why and by whom these expenses were furnished.		
Impairment Related–Expenses	**25 a** Do you have any impairment–related expenses that are necessary for you to work? (For example, prescription medications, medical services, attendant care, medical devices, equipment, prosthesis, or similar items or services.)	▶	❑ Yes ▶ Go to Item 25b ❑ No ▶ Go to Section 5
	b List each impairment-related expense and provide a receipt.		

Section 5 Information about Your Condition before Full Retirement Age

Condition Before Full Retirement Age

26 a Describe your present medical condition.

b Describe **any** change (better or worse) in your condition, if any, during the period shown in Section 1. If none, enter "None."

c Does your condition prevent you from working **now?** ▶ ❑ Yes ▶ Go to Item 26d ❑ No ▶ Go to Item 26e

d Have you received any treatment or care for your condition during the period shown in Section 1? ▶ ❑ Yes ▶ Go to Item 27 ❑ No ▶ Go to Item 28

e Explain why your condition does not prevent you from working now.

Treatment or Care

27 a (1) Enter the name and address of the most recent source of treatment or care (doctor, hospital, or clinic).

(2) Enter the Patient Number (if applicable).

(3) Enter the telephone number of the treatment source (include area code).
☎ ( )

(4) Enter the date(s) you were treated.

(5) Describe the condition(s) for which you received treatment.

(6) Describe the treatment.

Treatment or Care (Continued)

27 b (1) Enter the name and address of the second most recent source of treatment or care (doctor, hospital, or clinic).

(2) Enter the Patient Number (if applicable).

(3) Enter the telephone number of the treatment source (include area code).

☎ ( )

(4) Enter the date(s) you were treated.

(5) Describe the condition(s) for which you received treatment.

(6) Describe the treatment.

(If you need more space to list sources of care, continue in Section 6)

Medication

28 a Are you taking medication or receiving treatment now? ▶

❑ Yes ▶ Go to Item 28b

❑ No ▶ Go to Item 29

b Enter the medication or treatment below. **Note:** If you are taking prescription medication, furnish the name or type of medication and dosage from the label. (For example, Penicillin, 1.5 gram tablet, 3 times a day.)

Restriction of Activities

29 a Has your doctor restricted your activities? ▶ ❑ Yes ▶ Go to Item 29b ❑ No ▶ Go to Item 30

b Describe the restriction(s).

c Is the name of the doctor who restricted your activities different from the name of the doctor(s) shown in Item 27a or Item 27b? ▶ ❑ Yes ▶ Enter doctor's name then go to Item 30 ❑ No ▶ Go to Item 30

Doctor's Name: _____

Return to Work

30 a Has your doctor told you that you are able to return to work? ▶ ❑ Yes ▶ Go to Item 30b ❑ No ▶ Go to Item 31

b Enter the date your doctor said you could return to work.

Month	Day	Year

c Is the name of the doctor who told you that you are able to return to work different from the name of the doctor(s) shown in Item 27a or Item 27b? ▶ ❑ Yes ▶ Enter doctor's name then go to Item 31 ❑ No ▶ Go to Item 31

Doctor's Name: _____

Activities

31 Check the one box after each activity listed below that best describes your ability to do that activity.

- **"Yes"** — Means you can do the activity without help.
- **"No"** — Means you cannot do the activity even with help.
- **"Hard"** — Means the activity is hard for you to do, or that you need help. Explain each **"Hard"** answer.

Activity	Yes	No	Hard	Explanation
Walking	❑	❑	❑	
Eating	❑	❑	❑	
Bathing	❑	❑	❑	
Dressing, tying shoes, combing hair, etc.	❑	❑	❑	
Other bodily needs	❑	❑	❑	
Indoor chores (cooking, cleaning, etc.)	❑	❑	❑	
Outdoor chores (shopping, yardwork, etc.)	❑	❑	❑	
Driving a motor vehicle	❑	❑	❑	
Using public transportation	❑	❑	❑	
Talking to and dealing with other people	❑	❑	❑	

Rehabilitation Agency

32 a During the period shown in Section 1, have you received services, such as training, counseling, placement, medical examination, treatment, etc., from or through a state vocational rehabilitation agency? ▶ ❑ Yes ▶ Go to Item 32b ❑ No ▶ Go to Item 33

b Enter the Name, Address, and Telephone Number of your vocational rehabilitation counselor.

☎ ( )

c Enter the date(s) you received services.

d Describe the services you received.

Other Agencies

33 a During the period shown in Section 1, have you received services such as training, counseling, placement, medical examination, treatment, etc., from other agencies, such as VA, Worker's Compensation, Welfare, etc.? ▶ ❑ Yes ▶ Go to Item 33b ❑ No ▶ Go to Item 34

b Enter the Name, Address, and Telephone Number of the agency.

☎ ( )

c Enter your claim number at that agency.

d Enter the date(s) you received services.

Other Agencies (Continued)

33 e Describe the services you received.

Education

34 a Have you attended school (trade, vocational, or academic) during the period shown in Section 1? ▶ ❑ Yes ▶ Go to Item 34b ❑ No ▶ Go to Section 7

b Enter the Name, Address, and Telephone Number of the school.

☎ ( )

c Briefly describe the type of training you received.

d Enter the dates you attended the school.

Section 6 Continuation and Remarks

Continuation and Remarks

35 This section is to be used for the continuation of answers to other items. Be sure to include the item number at the beginning of the answer you wish to continue. You may also use this section to enter additional information that you feel may be important to include.

(Continue on next page)

Continuation and Remarks (Continued)

35

(If you need more space, attach a separate sheet of paper)

Section 7 Authorization and Certification

Authorization and Certification

36 Will this report be signed by a guardian or any other person representing the beneficiary? ▶

- ❑ Yes ▶ Read **Note** then go to Item 37
- ❑ No ▶ Go to Item 37

Note: *If answered "Yes," your guardian or representative must sign this report in Item 37.*

37 I understand that civil and criminal penalties may be imposed upon me for false or fraudulent statements, or for withholding information to misrepresent a fact or facts material to determining a right to benefits under the Railroad Retirement Act. I affirm that to the best of my knowledge, the information I have provided on this form is true, complete, and correct.

I have received the appropriate application booklets, **RB-1d,** ***Employee Disability Benefits,*** and **RB-9,** ***Employee and Spouse Events That Must Be Reported.*** I understand that I am responsible for reporting any events that would affect my annuity as explained in these booklets.

I authorize the Railroad Retirement Board to secure any information from the Social Security Administration which is required to determine my continuing entitlement to benefits under the Railroad Retirement Act.

Signature ▶

Date ▶

Month	Day	Year

Daytime Telephone Number (Include Area Code)

☎ ( )

38 If this certification is signed by mark ("X") in Item 37, two witnesses who know the person signing must sign below, giving their full addresses and daytime telephone numbers.

a. Signature of Witness

Address (Number and Street)

City, State, and ZIP Code

Daytime Telephone Number ▶

Area Code	Telephone Number

b. Signature of Witness

Address (Number and Street)

City, State, and ZIP Code

Daytime Telephone Number ▶

Area Code	Telephone Number

Section 8 How to Return Your Report

Before you return your report, check to make sure that:

- ***Every*** question that applies to you has been answered.
- You have entered "Unknown" in ***any*** answer space for which you were unable to answer a question.
- You have signed and dated the report.

When you received your report, you should also have received a pre-addressed return envelope. If you do not have this envelope, you can use any envelope as long as it is addressed to the RRB office shown below. No matter which envelope you use, you must put the correct postage on the envelope. Be careful to provide enough postage because your report may weigh more than a standard letter. The U.S. Postal Service will not deliver your report unless it has the correct postage.

Address envelope to:

U S Railroad Retirement Board
Disability Benefits Division
844 N Rush Street
Chicago IL 60611-2092

If you do not want to use the mail, you can send a facsimile of the entire report to:

- Facsimile Number
  (312) 751-7167

If you need information or assistance, contact:

-

☎ Telephone Number: