PROPOSED

U.S. RAILROAD RETIREMENT BOARD
Office of Programs - Operations
P. O. Box 10695
Chicago, Illinois 60610-0695

SI-1C (XX-XX) 06-24-08

~~In Reply Refer To~~
~~SS No. 307-60-6778~~
~~RE~~

REQUEST FOR INFORMATION ON ACCIDENT AND INSURANCE

Information requested on the back of this letter is needed in connection with your application for sickness benefits for your injury/illness of 06-18-08. The Railroad Retirement Board's (RRB) authority for requesting this information is section 5(b) and 12(o) of the Railroad Unemployment Insurance Act (RUIA). Because you are required to provide this information under section 9(a) of the RUIA, failure to complete and return this form could result in a fine or imprisonment or both.

Paperwork Reduction Act Notice: We estimate that this form takes an average of 5 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 or our estimate or any other aspect of this form, including suggestions for reducing completion time, to the Chief of Information Management, Railroad Retirement Board, 844 N. Rush Street, Chicago, IL 60611-2092.

RESOURCES

Robert J. Duda
Director of Operations

Form Approved
OMB No. 3220-0036

SUPPLEMENTAL INFORMATION ON ACCIDENT AND INSURANCE

1.A. Do you consider that any person or company was responsible for your injury or sickness? YES____ NO_____

B. If 'YES' give name and address of such person or company.
NAME:
ADDRESS:

2. Have you filed, or do you expect to file, a claim against such person or company? YES____ NO____

3. Were you injured while on duty? YES____ NO____

4. Did your sickness result from your work? YES___ NO____

5. Where did your injury take place? _____

6. What was the date of your injury or accident? MONTH___DAY___YEAR___

7.A. Were you injured in an automobile accident? YES___ NO___

B. If 'YES' give the following information about the automobiles involved:

DRIVER OR DRIVERS:

Name: Name:
Address: Address:

OWNER OR OWNERS:

Name: Name:
Address: Address:

INSURANCE COMPANY OR COMPANIES REPRESENTING DRIVER OR DRIVERS OF CAR(S) WHICH CAUSED YOUR INJURY (IF KNOWN). INFORMATION ABOUT YOUR OWN INSURER IS NOT NEEDED.

Name: Name:
Address: Address:

8. I certify that the information I am giving is true, complete and correct. I understand that criminal and civil penalties may be imposed on me for false or fraudulent statements or for withholding information to cause the payment of benefits by the RRB.

_____
SIGNATURE

_____
DATE

Return this form promptly to the address shown on the other side. Failure to return this form within 30 days could delay payment of benefits to you.

SI-1C (XX-XX)