RIGHTS REQUEST FORM

RRB Claim Number:
Overpayment Amount:
Letter Date:
Employee's Name:
Your Name:
Full Address:
Daytime Phone:
(Please enter any missing information or correct any errors.)

WHAT DO YOU REQUEST? *(place an "X"" opposite request choice)*

____ REVIEW OF THE FACTS ONLY – **(1)**

____ WAIVER ONLY – **(3)**
(Waiver requests made at any time will be accepted. However, if the request is not received within 60 days, any amounts collected prior to the request will not be waived.)

____ BOTH REVIEW OF THE FACTS AND WAIVER – **(2)**

Your remarks: *(Use the back of this form if necessary.)*

_____

_____

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If you wish to request your rights, sign this form and return it in the enclosed self-addressed return envelope to

Railroad Retirement Board
Retirement Survivor Debt Collections
PO Box 979018
St. Louis MO 63197-9000

Your Signature: _____ Date Signed: _____

For RRB Use Only: {B2- }