United States of America
Railroad Retirement Board

Form Approved
OMB No. 3220-0039

Application for Sickness Benefits

Section A Identifying Information

1. Employee's Name (First, Middle Initial, and Last)	2. Social Security Number
	___ – ___ – ____
3. Employee's Street Address, City, State and ZIP Code (Including Apartment Number)	4. Date of Birth (Month / Day / Year) ___ ___ / ___ ___ / ___ ___ 5. Sex ☐ Male ☐ Female
	6. Telephone Number (Include Area Code) ( )

Section B Infirmity and Employment Information

7. Date You Became Sick or Injured _____
8. Date You Last Worked for a Railroad _____
9. Last Railroad Employer (Name of Company) _____
10. Location of Last Railroad Employment (City/State) _____
11. Last Railroad Occupation _____
12. Department _____
13. If you worked for a nonrailroad employer after the date shown in Item 8, complete Items A, B, and C, below. Otherwise, **go to Item 14.**
    A. Last Nonrailroad Employer (Name of Company) _____
    B. Last Occupation After Railroad Work _____
    C. Date Last Worked After Railroad Work _____

Section C Accident and Insurance Information

14. Are you applying for sickness benefits because you were injured at work or have a work-related illness? ☐ Yes ☐ No
15. Have you filed or do you expect to file a lawsuit or claim against any person or company for personal injury?
    ☐ Yes - **Complete Items A-D, below** ☐ No - **Go to Item 16**
    A. Furnish the name and complete address of the person or company.
    Name _____
    Address _____
    City, State, ZIP Code _____
    B. Give the place where the injury occurred. _____
    C. Were you injured in an automobile accident? ☐ Yes ☐ No - **Go to Item 16**
    D. If you were injured in an automobile accident, provide information about all the vehicles, ***other than your own,*** that were involved in the accident that caused your injury. Information about your vehicle and insurance company is not needed. If you need more space attach a separate sheet of paper.

Owner of Car (other vehicle)	**Driver (other vehicle)**
Name	Name
Address	Address
City, State, ZIP Code	City, State, ZIP Code
Insurance Company (other vehicle)	**Policy Information (other vehicle)**
Name	Policy Number
Address	Claim Number
City, State, ZIP Code	

Continued on Reverse Side

Section D Claim for Sickness Benefits Information

16. Enter the earliest date you wish to claim sickness benefits. _____

17. Are you claiming all the days of sickness beginning with the date you entered in Item 16? (**Note:** You may claim rest days if you were unable to work and did not receive pay from your employer.) ❑ Yes - **Go to Item 19** ❑ No - **Go to Item 18**

18. Enter any dates that you do not wish to claim. _____

19. Enter the date you returned to work (if applicable). _____

20. **You must complete all boxes** to indicate if you have received or will receive any of the following payments for your days of sickness. If you check "YES" for any item, be sure to provide the requested information.

A. WAGES (Include Railroad and Nonrailroad Wages)

YES	NO	**If "YES," show the dates for which you were paid in Month/Day/Year format below.**
❑	❑	Regular Wages. . . . .
❑	❑	Vacation Pay . . . . .
❑	❑	Holiday Pay . . . . .
❑	❑	Military Reservist Pay . . . . .
❑	❑	Wage Continuation Pay . . . . .
❑	❑	Earnings from Self-Employment . .
❑	❑	Sick Pay from Your Employer . . . .

(but not payments supplementing Railroad Retirement Board (RRB) benefits. See Booklet UB-11)

B. GOVERNMENTAL PAYMENTS (Not RRB Sickness Benefits)

YES	NO	**If "YES," enclose copy of award letter and complete Items 1 - 3 below.**
❑	❑	Sickness or Unemployment Benefits Under Any Other Law
❑	❑	Social Security Benefits
❑	❑	Railroad Retirement or Disability Annuity
❑	❑	Military Retirement Pay
❑	❑	Worker's Compensation
❑	❑	Retirement Payments Under Another Law

1. Beginning Date of Payment _____
2. Gross Amount of Payment $ _____
3. How often do you receive the payment?
   ❑ Weekly ❑ Monthly ❑ Yearly
   ❑ Other: _____

C. OTHER PAYMENTS

YES	NO	**If "YES," complete Items 1 and 2.**
❑	❑	Settlement or Damages for Personal Injury
❑	❑	Advances
❑	❑	Separation Allowance (Buyout, Severance Pay)

1. Date of Payment _____
2. Paid By: _____

21. If the date you are submitting this form is **more than 30 days** after the date you entered in Item 16, answer the following:
A. Why did it take more than 30 days to submit this form? If more space is needed, attach a separate sheet of paper.

_____

B. How did you obtain this form? _____

C. Who provided this form to you? _____

D. On what date did you obtain the form? _____

E. Furnish the name and title of any person from whom you asked for help in completing and filing the forms.

NAME _____ TITLE _____

Section E Direct Deposit Information

22. Benefits are normally paid by Direct Deposit to your bank, savings and loan, credit union, or other financial institution. To provide the information we need to correctly deposit your payments, **attach a voided personal check and go to Item 23**, or call your financial institution for the information you need to complete Items A-E. If you do not have a bank account, or receiving your payments by Direct Deposit would cause you a hardship, **go to Item F.**

A. Routing Transit Number | | | | | | | | | | B. Account No. _____

C. Account Type:
❑ Checking ❑ Saving

D. Name of Financial Institution: _____

E. Telephone No. (Include Area Code) (_____) _____

F. ❑ Check this box if you do not have a checking, or savings account, or if Direct Deposit would cause you a hardship.

Section F Certification and Signature

23. I waive any "doctor-patient privilege" I may have with respect to the disclosure of information concerning the period of sickness or injury on which my claim is based. I certify that I understand and agree to the requirements in Booklet UB-11. I know that disqualification and civil and criminal penalties may be imposed on me for false or fraudulent statements or claims or for withholding information to get benefits from the RRB. I affirm that the information given on this form is true, correct and complete. **NOTE:** If the sick or injured employee is unable to sign this form, sign your name and complete Section I of the attached Form SI-10, Statement of Authority to Act for Employee.

SIGNATURE _____ **DATE** _____