

RIGHTS REQUEST FORM

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

YOUR REQUEST CHOICES (Place an "X" opposite your 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)
PERSONAL CONFERENCE (If you wish to request a personal conference, you must also make a request for a review of the facts and/or waiver.)

Your remarks: (Use the back of this form if necessary.)
[Blank lines for remarks]

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: { }