

## Application for Sickness Benefits

### Section A Identifying Information

1. Employee's Name (First, Middle Initial, and Last) _____	2. Social Security Number <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25px; height: 20px; border: 1px solid black;"></td> <td style="width: 25px; height: 20px; border: 1px solid black;"></td> <td style="width: 25px; height: 20px; border: 1px solid black;"></td> <td style="width: 25px; height: 20px; border: 1px solid black;"></td> <td style="width: 25px; height: 20px; border: 1px solid black;"></td> <td style="width: 25px; height: 20px; border: 1px solid black;"></td> <td style="width: 25px; height: 20px; border: 1px solid black;"></td> <td style="width: 25px; height: 20px; border: 1px solid black;"></td> <td style="width: 25px; height: 20px; border: 1px solid black;"></td> <td style="width: 25px; height: 20px; border: 1px solid black;"></td> <td style="width: 25px; height: 20px; border: 1px solid black;"></td> <td style="width: 25px; height: 20px; border: 1px solid black;"></td> <td style="width: 25px; height: 20px; border: 1px solid black;"></td> <td style="width: 25px; height: 20px; border: 1px solid black;"></td> </tr> </table>														
3. Employee's Street Address, City, State and ZIP Code (Including Apartment Number) _____	4. Date of Birth <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">Month</td> <td style="width: 25%; text-align: center;">Day</td> <td style="width: 50%; text-align: center;">Year</td> </tr> <tr> <td style="border: 1px solid black; height: 20px;"></td> <td style="border: 1px solid black; height: 20px;"></td> <td style="border: 1px solid black; height: 20px;"></td> </tr> </table>	Month	Day	Year				5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female							
Month	Day	Year													
	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.

<b>Owner of Car (other vehicle)</b>	<b>Driver (other vehicle)</b>
Name _____	Name _____
Address _____	Address _____
City, State, ZIP Code _____	City, State, ZIP Code _____
<b>Insurance Company (other vehicle)</b>	<b>Policy Information (other vehicle)</b>
Name _____	Policy Number _____
Address _____	Claim Number _____
City, State, ZIP Code _____	

**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?
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.

**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, Judgment 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.

- A. Routing Transit Number
B. Account No.
C. Account Type: Checking Saving
D. Name of Financial Institution:
E. Telephone No. (Include Area Code)

**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 1 of the attached Form SI-10, Statement of Authority to Act for Employee.

SIGNATURE DATE