UNITED STATES OF AMERICA
RAILROAD RETIREMENT BOARD

CURRENT

FORM APPROVED
O.M.B. No. 3220-0030

APPLICATION FOR DETERMINATION OF WIDOW(ER)'S DISABILITY

DO NOT WRITE IN THIS SPACE

OFFICIALLY FILED

MONTH	DAY	YEAR

OFFICE NUMBER

APPROVED

APPLICATION NUMBER

DATE CODED

MONTH	DAY	YEAR

CODED BY

Section 1 General Instructions

Before you complete this application, be sure to read Part I of booklet RB-17b, Widow(er)'s Disability Benefits, which explains information you will need to answer many of the questions in this application.

Please read "Important Notices" on page 11 of this application.

Print all answers in ink or use a typewriter. If you need more space than is provided to answer a question, use Section 9 for this purpose. If you do not know the answer to a question, print "unknown" in the space provided for the answer.

When entering dates, always use numbers. Also, be sure there is one number in each box. For example, you would enter December 13, 1998, as:

Month	Day	Year
1 2	1 3	9 8

Some items in this application will not apply to you so you will not need to answer them. Based on your answer to a question, you may be told to skip to another item number, or even another section. Follow the instructions that tell you to "Go to" another item. These are designed to save you time and help you move through the application form quickly filling in only necessary information. **If no "Go to" instructions are given, answer the next item in order. Do not skip any items unless directed to do so.**

If you are completing this application on behalf of someone else, you must answer each question as it applies to **the applicant.**

Section 2 Identifying Information

Check the information entered by the Railroad Retirement Board (RRB) for Items 1 through 6 for accuracy.

- ➤ If the information is correct, **go to Section 3.**
- ➤ If the information is not correct, cross out the incorrect information and enter the correct information above it.
- ➤ If the information is missing, fill it in.

Employee Identification	1		EMPLOYEE'S NAME →	
	2		EMPLOYEE'S SOCIAL SECURITY NUMBER →	
	3		EMPLOYEE'S RAILROAD RETIREMENT CLAIM NUMBER →	
Applicant Identification	4		APPLICANT'S NAME →	
	5	a	STREET ADDRESS →	
		b	CITY AND STATE →	
		c	ZIP CODE →	
		d	COUNTY →	
	6		DAYTIME TELEPHONE NUMBER →	

Section 3 Information About Your Medical Condition

Medical Condition

7 Describe the medical condition(s) causing you to file. Enter the exact diagnosis if known and any secondary condition.

When Condition Began

8 Enter the date this condition ***began*** to adversely affect your ability to work. → Month | Day | Year

How Condition Affects Work

9 Enter an "X" in the appropriate box:
I have worked since the date in Item 8. →
- ☐ Yes → **Go to Item 10**
- ☐ No → **Go to Item 12**

10 Enter an "X" in the appropriate box:
Did your condition cause you to change:

	Yes	No
Your job duties? →	☐	☐
Your hours of work? →	☐	☐
Your attendance? →	☐	☐
Anything else about your work? →	☐	☐
	If "Yes" to any item, go to Item 11	**If "No" to all items, go to Item 12**

11 Explain what the changes in your work circumstances were, the dates they occurred, and why your condition made these changes necessary.

Changes in Work Circumstances	Dates	Why Your Condition Made Changes Necessary

When Unable to Work

12 Enter the date you could no longer work because of your condition. → Month | Day | Year

13 Describe how your condition affects you and keeps you from working.

Current Work Status

14 Enter an "X" in the appropriate box:
My condition prevents me from working ***now.*** →
- ☐ Yes → **Go to Section 4**
- ☐ No → **Go to Item 15**

15 Enter the date you became able to work again. → Month | Day | Year

Section 4 Information About Your Medical Care

Medical Care or Examination

16 Enter an "X" in the appropriate box:
I have received medical care or been examined for my condition since the date in Item 8. →
- ☐ Yes → **Go to Item 17**
- ☐ No → **Go to Section 5**

Treatment or Testing

17 Enter an "X" in the appropriate box:
I have been treated or tested (inpatient or outpatient) at a hospital, institution or clinic, including a Department of Veterans Affairs or other government facility. →
- ☐ Yes → **Go to Item 18**
- ☐ No → **Go to Item 19**

Treatment or Testing (Continued) — 18

Enter information about each hospital, institution, or clinic where you have received treatment or care since the date in Item 8.

a

Name of Facility	Address and ZIP Code
Attending Physician's Name	
Enter an "X" in the appropriate box: Inpatient ❑ Outpatient ❑	
Patient Number	Area Code / Telephone Number
Dates Treated or Tested	Describe Type of Treatment or Testing

b

Name of Facility	Address and ZIP Code
Attending Physician's Name	
Enter an "X" in the appropriate box: Inpatient ❑ Outpatient ❑	
Patient Number	Area Code / Telephone Number
Dates Treated or Tested	Describe Type of Treatment or Testing

c

Name of Facility	Address and ZIP Code
Attending Physician's Name	
Enter an "X" in the appropriate box: Inpatient ❑ Outpatient ❑	
Patient Number	Area Code / Telephone Number
Dates Treated or Tested	Describe Type of Treatment or Testing

Doctor Treatment — 19

Enter an "X" in the appropriate box:
My personal physician or other doctor treated me since the date in Item 8. →

❑ Yes → **Go to Item 20**
❑ No → **Go to Item 21**

Doctor Treatment (Continued)

20 Enter information about each personal physician or other doctor who has treated you.

a

Name of Physician	Address and ZIP Code

Patient Number	Area Code	Telephone Number

Dates Treated or Examined	Describe Type of Treatment or Testing

b

Name of Physician	Address and ZIP Code

Patient Number	Area Code	Telephone Number

Dates Treated or Examined	Describe Type of Treatment or Testing

Activity Restriction

21 Enter an "X" in the appropriate box:
A medical doctor restricted my daily activities since the date in Item 8. →

❑ Yes → **Go to Item 22**
❑ No → **Go to Item 26**

22 Enter the name of the medical doctor who imposed the restriction. →

23 Enter the date the restriction began. →

MONTH	YEAR

24 Describe the restriction.

Activity Restriction (Continued)	25	Enter the address of the medical doctor in Item 22, if it has not previously been printed in Items 18 or 20. →	
Medication	26	Enter an "X" in the appropriate box: Medication has been prescribed for me. →	❑ Yes → **Go to Item 27** ❑ No → **Go to Section 5**
	27	Enter the name or type of medication and the dosage from the prescription label. Enter information for all medications prescribed for you.	
		NAME/TYPE:	DOSAGE:(grams, number of pills,etc.) / FREQUENCY:

Section 5 Information About Your Education and Training

Schooling	28	Enter the highest grade of school you completed and the last year you attended school. →	
	29	Enter an "X" in the appropriate box: I attended technical school. →	❑ Yes → **Go to Item 30** ❑ No → **Go to Item 33**
	30	Describe the type of technical school you attended.	
	31	Enter an "X" in the appropriate box: I received a certification or license from the technical school I attended. →	❑ Yes → **Go to Item 32** ❑ No → **Go to Item 33**
	32	Enter an "X" in the appropriate box: The certification or license I received is currently in effect. →	❑ Yes → **Go to Item 33** ❑ No → **Go to Item 33**
	33	Enter an "X" in the appropriate box: I have received specialized training. →	❑ Yes → **Go to Item 34** ❑ No → **Go to Section 6**
	34	Enter the type of specialized training you received and the period of time you received it.	
		TYPE	DATES
	35	Enter an "X" in the appropriate box: Have you used any of this training in your work? →	❑ Yes → **Go to Item 36** ❑ No → **Go to Section 6**
	36	Describe when and how you use(d) this training in your work.	

Section 6 Information About Your Daily Activities

Activities

37 After each activity listed below, check the one box that best describes your ability to do that activity.

- EASY — I can easily do the activity.
- HARD — I can do the activity with difficulty or with help.
- NOT AT ALL — I cannot do the activity even with help.

ACTIVITY	EASY	HARD	NOT AT ALL	EXPLANATION — Explain each "HARD" answer.
Sitting	❑	❑	❑	→
Standing	❑	❑	❑	→
Walking	❑	❑	❑	→
Eating	❑	❑	❑	→
Bathing	❑	❑	❑	→
Dressing (Tying Shoes, Combing Hair, Etc.)	❑	❑	❑	→
Other Bodily Needs	❑	❑	❑	→
Indoor Chores (Meal Preparation, Laundry, Cleaning, Etc.)	❑	❑	❑	→
Outdoor Chores (Shopping, Yardwork, Etc.)	❑	❑	❑	→
Driving a Motor Vehicle	❑	❑	❑	→
Using Public Transportation	❑	❑	❑	→
Conducting Personal Business (Talking to and Dealing with Other People)	❑	❑	❑	→
Reading English (For example, newspapers and magazines)	❑	❑	❑	→
Writing English (For example, notes and letters)	❑	❑	❑	→

38 Enter any additional information that describes your daily activities.

Section 7 Information About Your Work and Earnings

Work Activities

39 Enter an "X" in the appropriate box:
Have you ever been employed or self-employed? →

❑ Yes → **Go to Note and Item 40**

❑ No → **Go to Section 8**

Note: *If you answered "Yes"* ***and*** *you are a widow(er) filing for a* ***disability annuity****, also complete and return to the RRB* ***Form G-251, Vocational Report.***

Work for an Employer Last 12 Months

40 Enter an "X" in the appropriate box:
I have worked for pay for an employer in the last 12 months. (Do not include any self-employment.) →

❑ Yes → **Go to Item 41**
❑ No → **Go to Item 43**

41 Enter your earnings, before any deduction, for each month you have already worked ***this year.*** Then, starting with the current month, enter your expected gross earnings for this month and each remaining month this year.

JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE

JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER

42 Enter your earnings, before any deduction, for each month ***last year.***

JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE

JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER

Self-Employment Last 12 Months

43 Enter an "X" in the appropriate box:
Have you been self-employed in the last 12 months? →

❑ Yes → **Go to Item 44**
❑ No → **Go to Item 46**

44 Enter your ***net*** earnings for each month you have already worked ***this year.*** Then, starting with the current month, enter your expected earnings for this month and each remaining month this year.

JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE

JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER

45 Enter your ***net*** earnings, before any deduction, for each month ***last year.***

JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE

JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER

Work Next 12 Months

46 Enter an "X" in the appropriate box:
Do you expect to work during the next 12 months? (Include self-employment, if any.) →

❑ Yes → **Go to Item 47**
❑ No → **Go to Section 8**

47 Enter the name and address of the person or company for whom you expect to work. (If self-employed, enter "Self.") →

48 Enter the date(s) you expect to work. (For example, "June and July," "Indefinitely Starting 9-96," etc.) →

49 Enter the gross amount you expect to earn. (If you are self-employed, enter the **net** amount.) →

Section 8 General Information

Filing AA-17 or AA-18	50	Enter an "X" in the appropriate box: I am filing either ***Form AA-17*** or ***Form AA-18*** at this time. →	☐ Yes → **Go to Item 56** ☐ No → **Go to Item 51**
Social Security Benefits	51	Enter an "X" in the appropriate box: I have filed, or expect to file, for monthly social security disability benefits? →	☐ Yes → **Go to Item 52** ☐ No → **Go to Item 53**
	52	Enter the social security claim number under which you have filed or will file. →	
Public Service Pension	53	Enter an "X" in the appropriate box: I am receiving or expect to receive a pension or I have received or expect to receive a lump-sum payment instead of a pension based on my earnings from an agency of the Federal, state, or local government. (Answer "NO" if your only government pension payments are social security, railroad retirement, veterans affairs, worker's compensation, or black lung benefits. Also answer "NO" if you received a lump-sum payment that was just your contributions to the pension fund plus interest.)	☐ Yes → **Go to Item 54** ☐ No → **Go to Item 56**
	54	I am/was an employee of the Federal Government.	☐ Yes → **Go to Note and Item 56** ☐ No → **Go to Item 55**
		Note: *If answered "Yes," also complete and return the RRB* ***Form G-208, Public Service Pension Questionnaire****, and verification of your pension.*	
	55	Enter an "X" in the appropriate box: On my last day of employment, I was employed by a state or local government or the military service and social security (FICA) taxes were being deducted from my public service earnings.	☐ Yes → **Go to Item 56** ☐ No → **Go to Note and Item 56**
		Note: *If answered "No," also complete and return the RRB* ***Form G-208, Public Service Pension Questionnaire****, and verification of your pension.*	
Criminal Offense	56	Enter an "X" in the appropriate box: Within the past 12 months, I have been imprisoned or given a sentence of confinement due to a conviction for a criminal offense. →	☐ Yes → **Go to Item 57** ☐ No → **Go to Section 9**
	57	Enter the date of the conviction. →	Month / Day / Year
	58	Enter an "X" in the appropriate box: Is your disability related to the commission of the criminal offense? →	☐ Yes ☐ No
	59	Enter the date of the sentence of confinement. →	Month / Day / Year
	60	Enter the date that confinement began. →	Month / Day / Year
	61	Enter an "X" in the appropriate box: Is your disability related to your confinement? →	☐ Yes ☐ No
	62	Enter an "X" in the appropriate box: Has the confinement ended? →	☐ Yes → **Go to Item 63** ☐ No → **Go to Section 9**
	63	Enter the date confinement ended. →	Month / Day / Year

Section 9 Remarks

Remarks	64	This section is to be used for the continuation of answers to other items. Be sure to include the item number at the beginning of the answer you wish to continue. You may also use this space to enter any additional information that you feel may be important to include.

Section 10 Certification

Certification

65 Enter an "X" in the appropriate box:
I will have a guardian or other representative sign this application on my behalf. →

❑ Yes → **Go to Note and Item 66**
❑ No → **Go to Item 66**

Note: *If answered "Yes," your guardian or other representative must sign this application. That person must also complete and return* ***Form AA-5, Application for Substitution of Payee.***

66 I know that if I make a false or fraudulent statement in order to receive benefits from the RRB, or if I fail to disclose earnings or report employment of any kind to the RRB, I am committing a crime which is punishable under Federal law.

I have received the booklet ***RB-17b, Widow(er)'s Disability Benefits*****.** I understand that I am responsible for reporting any events that would affect my annuity, as explained in that booklet.

I certify that the information I gave to the RRB on this application is true to the best of my knowledge.

I agree to immediately notify the RRB:

- If I perform work for any employer, railroad or nonrailroad, or perform any self-employment work;
- If my condition improves;
- If I am confined in a jail, prison, penal institution, or correctional facility due to a conviction for a criminal offense.
- If my address changes;
- If I remarry;
- If I file for social security benefits based on ***any*** person's earnings record;
- If I begin to receive a pension from an agency of the Federal, state, or local government or if my present payments change.

I know that if I am receiving a disability annuity and fail to report work and earnings promptly, I am committing a crime punishable by Federal law and may result in criminal prosecution and/or penalty deductions in my annuity payments.

Signature →

(First Name, Middle Initial, Last Name)

Date →

Month	Day	Year

67 If this certification is signed by mark ("X") in Item 66, two witnesses who know the person signing must sign below, giving their full addresses and daytime telephone numbers.

a **Signature of Witness**

Address (Number and Street)

City, State, and ZIP Code

Daytime Telephone Number → Area Code | Telephone Number

b **Signature of Witness**

Address (Number and Street)

City, State, and ZIP Code

Daytime Telephone Number → Area Code | Telephone Number

Section 11 How To Return Your Application

Before you return your application, check to make sure that:

- ***Every*** question that applies to you has been answered.
- You have entered "unknown" in ***any*** answer space for which you were unable to answer a question.
- You have signed and dated the application.
- You have included ***all*** the needed proofs listed in the letter you received with this application.

When you received your application, you should also have received a pre-addressed return envelope. If you do not have this envelope, you can use any envelope as long as it is addressed to the RRB office shown on page 12 of this application. No matter which envelope you use, you must put the correct postage on the envelope. Be careful to provide enough postage, because your application and the accompanying forms may weigh more than a standard letter. The U.S. Postal Service will not deliver your application unless it has the correct postage.

Make one final check before you seal the envelope to ensure that the following are enclosed:

- NEEDED PROOFS
- THE APPLICATION FORM ITSELF
- ADDITIONAL FORMS YOU WERE ASKED TO COMPLETE

Note: *Make no entries on page 12, which is the receipt for your claim. After the RRB receives your application, they will complete the blanks on the receipt and send it back to you. When it is returned to you, you will know that the RRB has received your application and has started the work needed to determine if you are entitled to benefits. If you do not receive the receipt within two weeks after you filed this application, please contact us so we can find out what is causing the delay.*

Important Notices

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

The information asked for in this form is needed to determine your entitlement to benefits under the Railroad Retirement Act. The RRB's authority for requesting this information is Section 7(b)(6) of the Railroad Retirement Act.

We estimate that this form takes and average of 40 to 50 minutes per response 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 our estimate or any other aspect of this form, including suggestions for reducing the completion time, to Chief of Information Resources Management, Railroad Retirement Board, 844 North Rush Street, Chicago, IL 60611-2092.

COMPUTER MATCHING AND PRIVACY PROTECTION ACT NOTICE

The Computer Matching and Privacy Protection Act of 1988 requires the RRB to advise you that information you have provided may be used, without your consent, in automated matching programs. These matching programs are a computer comparison of RRB records with records kept by other Federal, state, or local governmental agencies. Information from these matching programs can be used to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Receipt For Your Claim

EMPLOYEE'S NAME		
APPLICANT'S NAME	RAILROAD RETIREMENT BOARD CLAIM NUMBER	DATE CLAIM RECEIVED

Your application for railroad retirement disability benefits has been received and will be processed as quickly as possible. If you change your address, or if there is some other change that may affect your claim, you or your representative should report the change. The changes to be reported are listed below. Always give us your claim number when writing or calling about your claim. If you have any questions about your claim we will be glad to help you. If you need to personally visit one of our field offices, please call for an appointment. You will not be refused service if you do not have an appointment, but our staff can serve you better when an appointment is made. Most offices are open to the public from 9:00 AM to 3:30 PM, Monday through Friday.

Always Report These Changes To The RRB

- **Address** — If your address changes.
- **Work** — If I perform work for any employer, railroad or nonrailroad, or perform any self-employment work.
- **Remarriage** — If you remarry.
- **Condition** — If your condition improves.
- **Social Security** — If you file for benefits on ***any*** person's earnings.
- **Criminal Offense** — If you are confined in a jail, prison, penal institution, or correctional facility due to a conviction for a criminal offense.
- **Public Service Pension** — If you begin to receive a pension from an agency of the Federal, state, or local government or if your present payments change.

How To Report Changes

When a change occurs after you are entitled to disability benefits, you should report the change at once. You or your representative can make the reports by telephone, mail, or in person, whichever you prefer.

To report any of the above changes, contact:

▶

☎ Telephone Number:

If for some reason you cannot contact that office, you should contact:

▶ U S RAILROAD RETIREMENT BOARD
844 N RUSH ST
CHICAGO IL 60611-2092