

# Application For Determination Of Employee's Disability

**Do Not Write In This Space**

Officially Filed

| Month | Day | Year |
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Office Number

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Date Coded

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**Section 1 General Instructions**

Before you complete this application, be sure to read Part 1 of booklet RB-1d, Employee Disability Benefits, which explains information you will need to answer many of the questions in this application. Please read "Important Notices" on page 15 of this application.

Print legibly in ink. If you need more space than is provided to answer a question, use Section 9, **Remarks**, 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 June 06, 2016, as:

| Month | Day   | Year          |
|-------|-------|---------------|
| 0   6 | 0   6 | 2   0   1   6 |

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 5 for accuracy.

- ▶ If the information is correct, **go to Section 3.**
- ▶ If the information is not correct, enter the correct information.
- ▶ If the information is missing, fill it in.

|   |  |  |                                     |
|---|--|--|-------------------------------------|
| Employee Identification                   | 1 Employee's Name                                      |  |                                     |
|   | 2 Employee's Railroad Retirement Claim Number<br><br>A |  | 3 Employee's Social Security Number |
|   | 4a Employee's Street Address                           |  |                                     |
|   | b City and State/Province                              |  | c ZIP Code                          |
|   | d Country  |  |                                     |
| 5a Daytime Telephone Number<br><br>(    ) |  | b Alternate Telephone Number<br><br>(    ) |                                     |

### Section 3 Information About Your Medical Condition

|  |   |                  |                              |  |       |     |      |  |  |  |
|--|---|------------------|------------------------------|--|-------|-----|------|--|--|--|
| Medical Condition  | 6 Describe the medical condition(s) causing you to file. Enter the exact primary diagnosis if known and any additional condition(s). Also enter if no medical records are being forwarded for each condition described. |                  |                              |  |       |     |      |  |  |  |
|  | Primary Condition   | Medical Attached | <input type="checkbox"/> Yes | <input type="checkbox"/> No  |       |     |      |  |  |  |
|  | Additional Condition(s)   | Medical Attached | <input type="checkbox"/> Yes | <input type="checkbox"/> No  |       |     |      |  |  |  |
| When Condition Began   | 7 Enter the date the condition(s) <b>began</b> to affect your ability to work. ▶  |                  |                              | <table border="1" 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="text-align:center;">   </td> <td style="text-align:center;">   </td> <td style="text-align:center;">       </td> </tr> </table> | Month | Day | Year |  |  |  |
|  | Month   | Day              | Year                         |  |       |     |      |  |  |  |
|  |   |                  |                              |  |       |     |      |  |  |  |
| How Condition Affects Work                                   | 8 Enter an "X" in the appropriate box: Have you worked since the date in Item 7? ▶  |                  |                              | <input type="checkbox"/> Yes ▶ <b>Go to Item 9</b><br><input type="checkbox"/> No ▶ <b>Go to Item 10</b>   |       |     |      |  |  |  |
|  | 9a Enter an "X" in the appropriate box: Has your condition(s) caused you to change any aspect of your work (such as job duties, hours of work, attendance, etc.)? ▶   |                  |                              | <input type="checkbox"/> Yes ▶ <b>Go to Item 9b</b><br><input type="checkbox"/> No ▶ <b>Go to Item 10</b>  |       |     |      |  |  |  |
|  | b Explain what the changes in your work circumstances were, the dates they occurred, and why your condition(s) made these changes necessary.  |                  |                              |  |       |     |      |  |  |  |
|  | CHANGES   | DATES            | CONDITION                    |  |       |     |      |  |  |  |
| When Unable To Work  | 10 Enter the date you could no longer work because of your condition(s). ▶  |                  |                              | <table border="1" 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="text-align:center;">   </td> <td style="text-align:center;">   </td> <td style="text-align:center;">       </td> </tr> </table> | Month | Day | Year |  |  |  |
|  | Month   | Day              | Year                         |  |       |     |      |  |  |  |
|  |   |                  |                              |  |       |     |      |  |  |  |
| 11 Describe how your condition(s) prevents you from working. |   |                  |                              |  |       |     |      |  |  |  |
| Current Work Status  | 12a Enter an "X" in the appropriate box: Have you relinquished your rights? ▶   |                  |                              | <input type="checkbox"/> Yes ▶ <b>Go to Item 12b</b><br><input type="checkbox"/> No ▶ <b>Go to Item 13</b>   |       |     |      |  |  |  |
|  | b Enter the reason why you relinquished your rights.  |                  |                              |  |       |     |      |  |  |  |
|  | 13a Enter an "X" in the appropriate box: Did you attempt to go back to work and were you unable to do so? ▶   |                  |                              | <input type="checkbox"/> Yes ▶ <b>Go to Item 13b</b><br><input type="checkbox"/> No ▶ <b>Go to Section 4</b>   |       |     |      |  |  |  |
| b Enter the date(s) of the work attempts.                    |   |                  |                              |  |       |     |      |  |  |  |

**Section 4 Information About Your Medical Care**

Medical Care or Examination

14a Enter an "X" in the appropriate box:  
 Have you received medical care or been examined for your condition(s) since the date in Item 7?  Yes  
 No

---

b Enter an "X" in the appropriate box:  
 Are you scheduled for any additional medical care for your condition(s) (i.e., surgeries, etc.) **after** you file this application?  Yes ▶ **Explain below**  
 No ▶ **Go to Item 15**

Explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Treatment or Testing

15 Enter an "X" in the appropriate box:  
 Have you 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 16**  
 No ▶ **Go to Item 17**

16 Enter information about each hospital, institution, or clinic where you have received treatment or care since the date in item 7.

|  |  |
|--|--|
| a Name of Facility   | Address of Facility (Street Address, City, State/Province, and ZIP Code) |
| Attending Physician's Name   |  |
| Enter an "X" in the appropriate box:<br>Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> |  |
| Patient Number   | Telephone Number (Include Area Code)<br>(      )                         |

|                         |                                       |
|-------------------------|---------------------------------------|
| Dates Treated or Tested | Describe Type of Treatment or Testing |
|-------------------------|---------------------------------------|

|  |  |
|--|--|
| b Name of Facility   | Address of Facility (Street Address, City, State/Province, and ZIP Code) |
| Attending Physician's Name   |  |
| Enter an "X" in the appropriate box:<br>Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> |  |
| Patient Number   | Telephone Number (Include Area Code)<br>(      )                         |

|                         |                                       |
|-------------------------|---------------------------------------|
| Dates Treated or Tested | Describe Type of Treatment or Testing |
|-------------------------|---------------------------------------|

|                             |  |                                       |  |                                      |
|-----------------------------|--|---------------------------------------|--|--------------------------------------|
| Treatment or Testing (Cont) | 16c Name of Facility   |                                       | Address of Facility (Street Address, City, State/Province, and ZIP Code) |                                      |
|                             | Attending Physician's Name   |                                       |  |                                      |
|                             | Enter an "X" in the appropriate box:<br>Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> |                                       |  |                                      |
|                             | Patient Number   |                                       |  | Telephone Number (Include Area Code) |
|                             |  |                                       |  | (      )                             |
| Dates Treated or Tested     |  | Describe Type of Treatment or Testing |  |                                      |

|                  |  |  |  |   |
|------------------|--|--|--|---|
| Doctor Treatment | 17 Enter an "X" in the appropriate box:<br>Has your personal physician or other doctor treated you since the date in Item 7? |  |  | <input type="checkbox"/> Yes    ▶ <b>Go to Item 18</b><br><input type="checkbox"/> No      ▶ <b>Go to Item 19</b> |
|------------------|--|--|--|---|

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

|                           |  |  |  |
|---------------------------|--|--|--|
| a Name of Physician       |  | Address of Facility (Street Address, City, State/Province, and ZIP Code) |  |
| Patient Number            |  | Telephone Number (Include Area Code)                                     |  |
|                           |  | (      )   |  |
| Dates Treated or Examined |  | Describe Type of Treatment or Examination                                |  |

|                           |  |  |  |
|---------------------------|--|--|--|
| b Name of Physician       |  | Address of Facility (Street Address, City, State/Province, and ZIP Code) |  |
| Patient Number            |  | Telephone Number (Include Area Code)                                     |  |
|                           |  | (      )   |  |
| Dates Treated or Examined |  | Describe Type of Treatment or Examination                                |  |

|                         |                           |  |  |
|-------------------------|---------------------------|--|--|
| Doctor Treatment (Cont) | 18c Name of Physician     | Address of Facility (Street Address, City, State/Province, and ZIP Code) |  |
|                         | Patient Number            | Telephone Number (Include Area Code)<br>(      )                         |  |
|                         | Dates Treated or Examined | Describe Type of Treatment or Examination                                |  |

|   |  |  |  |  |
|---|--|--|--|--|
| Railroad Employer Examination   | 19 Enter an "X" in the appropriate box:<br>Has your railroad employer referred you to a medical source for examination or treatment within 18 months of filing this application? |  |  | <input type="checkbox"/> Yes ▶ <b>Go to Item 20</b>          |
|   |  |  |  | <input type="checkbox"/> No ▶ <b>Go to Item 21</b>           |
|   | 20 Enter information about this examination or treatment.  |  |  |  |
|   | Name of Medical Source   |  | Address of Source (Street Address, City, State/Province, and ZIP Code) |  |
|   | Attending Physician's Name   |  |  |  |
|   | Enter an "X" in the appropriate box:<br>Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/>   |  |  |  |
| Patient Number  |  | Telephone Number (Include Area Code)<br>(      ) |  |  |
| Dates Treated or Examined   |  | Describe Type of Treatment or Examination        |  |  |
| 21 Enter an "X" in the appropriate box:<br>Have you been medically disqualified for work by your employer?  |  |  |  | <input type="checkbox"/> Yes ▶ <b>Go to Note and Item 22</b> |
|   |  |  |  | <input type="checkbox"/> No ▶ <b>Go to Item 22</b>           |
| <div style="border: 1px solid black; border-radius: 15px; padding: 5px; display: inline-block;"> <b>Note:</b> <i>If answered "Yes," you must submit a copy of the Disqualification Notice.</i> </div> |  |  |  |  |

|  |  |  |   |   |       |      |  |  |
|--|--|--|---|---|-------|------|--|--|
| Activity Restriction                     | 22 Enter an "X" in the appropriate box:<br>Has a medical doctor restricted your daily activities since the date in item 7?   |  |   | <input type="checkbox"/> Yes ▶ <b>Go to Item 23</b>   |       |      |  |  |
|  |  |  |   | <input type="checkbox"/> No ▶ <b>Go to Item 26</b>  |       |      |  |  |
|  | 23 Enter the name of the medical doctor who imposed the restriction. Also enter the medical doctor's address if it has not previously been entered in items 16, 18, or 20. |  |   |   |       |      |  |  |
| Name of Medical Doctor                   |  | Address of Medical Doctor (Street Address, City, State/Province, and ZIP Code) |   |   |       |      |  |  |
| 24 Enter the date the restriction began. |  |  | ▶ | <table border="1" style="width: 100%; text-align: center;"> <tr> <td>Month</td> <td>Year</td> </tr> <tr> <td>   </td> <td>       </td> </tr> </table> | Month | Year |  |  |
| Month                                    | Year   |  |   |   |       |      |  |  |
|  |  |  |   |   |       |      |  |  |

| Activity Restriction (Cont) | 25 List and describe the condition(s) and how your daily activities were restricted by the condition(s).   |           |                                       |           |  |  |
|-----------------------------|--|-----------|---------------------------------------|-----------|--|--|
| Medication                  | 26a Enter an "X" in the appropriate box:<br>Are you currently taking prescribed medication(s)? <input type="checkbox"/> Yes ▶ <b>Go to Item 26b</b><br><input type="checkbox"/> No ▶ <b>Go to Section 5</b>  |           |                                       |           |  |  |
|                             | b Enter from the prescription labels the following information for all medications prescribed for you:<br>Name or type of medication, dosage, and frequency. (For example, Penicillin, 1.5 gram tablet, 3 times a day.)  |           |                                       |           |  |  |
|                             | <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 45%;">Name/Type</th> <th style="width: 30%;">Dosage (Grams, Number of Pills, Etc.)</th> <th style="width: 25%;">Frequency</th> </tr> </thead> <tbody> <tr> <td style="height: 100px;"> </td> <td> </td> <td> </td> </tr> </tbody> </table> | Name/Type | Dosage (Grams, Number of Pills, Etc.) | Frequency |  |  |
| Name/Type                   | Dosage (Grams, Number of Pills, Etc.)  | Frequency |                                       |           |  |  |
|                             |  |           |                                       |           |  |  |

**Section 5 Information About Your Education And Training**

| Schooling  | 27 Enter the highest grade of school you completed. ▶  |  |       |     |      |  |  |  |
|--|--|--|-------|-----|------|--|--|--|
| Schooling  | 28a Are you currently attending school (including online)? <input type="checkbox"/> Yes ▶ <b>Go to Item 28b</b><br><input type="checkbox"/> No ▶ <b>Go to Item 29</b>  |  |       |     |      |  |  |  |
|  | b Enter the date you began attending. ▶ _____ to Present   |  |       |     |      |  |  |  |
|  | c Enter an "X" in the appropriate box:<br>Indicate what type of school you are attending or enter the services you receive. Use "Other" to indicate any other type of school not listed.<br><b>Skip Item 29 and go to Item 30b.</b>  | <input type="checkbox"/> Technical<br><input type="checkbox"/> Specialized<br><input type="checkbox"/> Vocational<br><input type="checkbox"/> Services: _____<br><input type="checkbox"/> Other: _____   |       |     |      |  |  |  |
|  | 29 Enter the date that you last attended school. ▶   | <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;">Month</th> <th style="width: 33%;">Day</th> <th style="width: 33%;">Year</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"> </td> <td style="text-align: center;"> </td> <td style="text-align: center;"> </td> </tr> </tbody> </table> | Month | Day | Year |  |  |  |
|  | Month  | Day  | Year  |     |      |  |  |  |
|  |  |  |       |     |      |  |  |  |
| 30a Enter an "X" in the appropriate box:<br>Have you attended technical school, or received specialized/vocational training or services?                 | <input type="checkbox"/> Yes ▶ <b>Go to Item 30b</b><br><input type="checkbox"/> No ▶ <b>Go to Item 31</b>   |  |       |     |      |  |  |  |
| b Describe the type of technical school you attended, or training or services you received and the period of time you attended or received the training. | <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">Type</th> <th style="width: 25%;">From</th> <th style="width: 25%;">To</th> </tr> </thead> <tbody> <tr> <td style="height: 50px;"> </td> <td> </td> <td> </td> </tr> </tbody> </table> | Type   | From  | To  |      |  |  |  |
| Type   | From   | To   |       |     |      |  |  |  |
|  |  |  |       |     |      |  |  |  |
| 31 Enter an "X" in the appropriate box:<br>Have or will you receive a degree, certificate, or license for any training you received?                     | <input type="checkbox"/> Yes ▶ <b>Go to Item 32</b><br><input type="checkbox"/> No ▶ <b>Go to Section 6</b>  |  |       |     |      |  |  |  |
| 32 Enter an "X" in the appropriate box:<br>Is the degree, certificate, or license you received currently valid?  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No  |  |       |     |      |  |  |  |
| 33 Enter an "X" in the appropriate box:<br>Have you used any of this training in your work?  | <input type="checkbox"/> Yes ▶ <b>Go to Item 34</b><br><input type="checkbox"/> No ▶ <b>Go to Section 6</b>  |  |       |     |      |  |  |  |

34 Describe when and how you have used this training in your work.

**Section 6 Information About Your Daily Activities**

Activities

35 Check the one box after each activity listed below that best describes your ability to do that activity.

- EASY - I can easily do the activity.
- DIFFICULT - I can do the activity with difficulty.
- HARD - I can only do the activity with assistance.
- NOT AT ALL - I cannot do the activity even with assistance.
- N.A. - Not applicable.

| Activity  | Easy                     | Difficult                | Hard                     | Not At All               | N.A.                     |   | Explain each "DIFFICULT," "HARD," and "NOT AT ALL" answer |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---|---|
| Sitting   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ▶ |   |
| Standing  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ▶ |   |
| Walking   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ▶ |   |
| Eating  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ▶ |   |
| Bathing   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ▶ |   |
| Dressing (Tying Shoes, Combing Hair, etc.)                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ▶ |   |
| Other Bodily Needs  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ▶ |   |
| Indoor Chores (Meal Preparation, Laundry, Cleaning, etc.)               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ▶ |   |
| Outdoor Chores (Shopping, Yardwork, etc.)                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ▶ |   |
| Driving a Motor Vehicle   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ▶ |   |
| Using Public Transportation   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ▶ |   |
| Conducting Personal Business (Talking to and Dealing with Other People) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ▶ |   |
| Reading English (For example, newspapers and magazines)                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ▶ |   |
| Writing English (For example, notes and letters)                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ▶ |   |

Activities  
(Cont)

36 Describe your daily activities during a normal day (i.e., a typical day from the time you get up until you go to bed.)

37a Do you perform any volunteer work? (Volunteer work is any work performed without pay.)  Yes ▶ Go to Item 37b  No ▶ Go to Item 38

b Describe the volunteer work that you perform and enter the number of average hours you participate per week.

| Volunteer Work | Average Hours Per Week |
|----------------|------------------------|
|                |                        |

38a Do you participate in social or recreational activities? For example, clubs, traveling, exercise, indoor/outdoor sports, hobbies/crafts, etc.  Yes ▶ Go to Item 38b  No ▶ Go to Section 7

b Describe the social or recreational activities that you participate in and enter the number of average hours you participate per week.

| Activity | Average Hours Per Week |
|----------|------------------------|
|          |                        |

c Does your condition(s) restrict your participation in the activities listed above?  Yes ▶ Go to Item 38d  No ▶ Go to Section 7

d Describe the changes.

### Section 7 Information About Your Work And Earnings

Work for an  
Employer  
Last 12  
Months

39 Enter an "X" in the appropriate box: Have you worked and received pay from a railroad or nonrailroad employer in the last 12 months? (Do not include any self-employment.)  Yes ▶ Go to Item 40  No ▶ Go to Item 41

40 Enter your earnings before any deductions 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 |
|         |          |           |         |          |          |



Work for an Employer Previous Calendar Year

41 Enter your earnings before any deductions for each month **last year**.

|         |          |           |         |          |          |
|---------|----------|-----------|---------|----------|----------|
| January | February | March     | April   | May      | June     |
|         |          |           |         |          |          |
| July    | August   | September | October | November | December |
|         |          |           |         |          |          |

Work Next 12 Months

42 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 43**  
▶  No ▶ **Go to Section 8**

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

▶

44 Enter the date(s) you expect to work.  
(For example: "June and July";  
Indefinitely starting 6-16; etc.)

▶

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

▶

**Section 8 General Information**

Filing AA-1

46 Enter an "X" in the appropriate box:  
Are you filing Form AA-1 at this time?

▶  Yes ▶ **Go to Item 55**  
▶  No ▶ **Go to Item 47**

Self-Employment

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

▶  Yes ▶ **Go to Note and Item 48**  
▶  No ▶ **Go to Item 49**

**Note:** If answered "Yes," also complete and return to the RRB Form AA-4, Self Employment Questionnaire.

48 Enter an "X" in the appropriate box:  
Are you a corporate officer or owner/operator of a corporation?

▶  Yes ▶ **Go to Note and Item 49**  
▶  No ▶ **Go to Item 49**

**Note:** If answered "Yes," also complete and return to the RRB Form G-252, Self-Employment/Corporate Officer Work and Earnings Monitoring.

Worker's Compensation

49 Enter an "X" in the appropriate box:  
Since the date in Item 7, have you received, or do you expect to receive, worker's compensation payments?

▶  Yes ▶ **Go to Note and Item 50**  
▶  No ▶ **Go to Item 50**

**Note:** Proof of the amount(s) and effective date(s) of your worker's compensation are required.

Public Disability Benefits

50 Enter an "X" in the appropriate box:  
 Since the date in Item 7, have you received, or do you expect to receive, disability benefits under a Federal, state, or local government plan or law based on employment **not** covered under the Social Security Act? (Answer "No" if your benefits are railroad retirement, social security, veterans affairs or welfare benefits.)

Yes ▶ **Go to Note and Item 51**  
 No ▶ **Go to Item 51**

**Note:** Proof of the amount(s) and effective date(s) of your public disability are required.

Social Security Benefits

51 Enter an "X" in the appropriate box:  
 Have you filed, or do you expect to file, for monthly social security disability benefits or Supplemental Security Income?

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.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|

Liabilities

53 Have you applied for sickness benefits because you were injured at work or have a work-related illness?

Yes ▶ **Go to Item 54**  
 No ▶ **Go to Item 55**

54 Have you filed or do you expect to file a lawsuit or claim against any person or company for personal injury?

Yes  
 No

Criminal Offenses

55 Enter an "X" in the appropriate box:  
 Within the past 12 months, have you been imprisoned or given a sentence of confinement due to a conviction for a criminal offense?

Yes ▶ **Go to Item 56**  
 No ▶ **Go to Section 9**

56 Enter the date of the conviction.

|   | Month | Day | Year |
|---|-------|-----|------|
| ▶ |       |     |      |

57 Enter an "X" in the appropriate box:  
 Is your disability related to the commission of the criminal offense?

Yes  
 No

58 Enter the date of the sentence of confinement.

|   | Month | Day | Year |
|---|-------|-----|------|
| ▶ |       |     |      |

59 Enter the date that confinement began.

|   | Month | Day | Year |
|---|-------|-----|------|
| ▶ |       |     |      |

60 Enter an "X" in the appropriate box:  
 Is your disability related to your confinement?

Yes  
 No

61 Enter an "X" in the appropriate box:  
 Has the confinement ended?

Yes ▶ **Go to Item 62**  
 No ▶ **Go to Section 9**

62 Enter the date confinement ended.

|   | Month | Day | Year |
|---|-------|-----|------|
| ▶ |       |     |      |



## Section 10 Relinquishment Of Rights By Disability Annuity Applicant Only

I authorize the RRB to relinquish any rights I may have to return to work for a railroad employer, which will affect the payment of my own or my spouse's annuity. Based on this authorization, my rights will be relinquished when I reach full retirement age (FRA) or at age 60-FRA if I become entitled to a supplemental annuity or if my spouse becomes entitled to a spouse's annuity. I understand this authorization remains in effect unless my disability annuity terminates before FRA or before a supplemental or spouse's annuity becomes payable. My rights will also be relinquished if I am eligible for a reduced age and service annuity and choose to receive this type of annuity if my disability is denied.

## Section 11 Certification

| Certification   | <p>64a Did you complete this application with the assistance of an attorney or non-family member? ▶</p>  | <input type="checkbox"/> Yes ▶ <b>Go to Item 64b</b><br><input type="checkbox"/> No ▶ <b>Go to Item 65</b>         |  |       |     |      |  |  |  |
|---|--|--|--|-------|-----|------|--|--|--|
|   | <p>b Enter the name and address of the attorney or non-family member who assisted with completing this application. ▶</p>  |  |  |       |     |      |  |  |  |
|   | <p>c Did you pay a fee to the attorney or non-family member who assisted with completing this application? ▶</p>   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No  |  |       |     |      |  |  |  |
|   | <p>65 Enter an "X" in the appropriate box:<br/>Will you have a guardian or other representative sign this application on your behalf? ▶</p>  | <input type="checkbox"/> Yes ▶ <b>Go to Note and Item 66</b><br><input type="checkbox"/> No ▶ <b>Go to Item 66</b> |  |       |     |      |  |  |  |
| <p><b>Note:</b> If answered "Yes," the guardian or other representative of the applicant must sign this application. That person must also complete and return <b>Form AA-5, Application for Substitution Of Payee.</b></p> |  |  |  |       |     |      |  |  |  |
|   | <p>66 I certify that the information I gave the Railroad Retirement Board (RRB) on this application is true to the best of my knowledge. I know that if I make a false or fraudulent statement or withhold information in order to receive benefits from the RRB, I am committing a crime under Federal law which may be punishable by fines, imprisonment, or both. I have received and reviewed the booklets, <b>RB-1d, Employee Disability Benefits</b>, and <b>RB-9, Employee and Spouse Annuities Events That Must Be Reported</b>. I understand that I am responsible for reporting events that would affect my annuity as explained in the booklets.</p> <p>I agree to immediately notify the RRB:</p> <ul style="list-style-type: none"> <li>• If I work for any employer, railroad or nonrailroad, or perform any self-employment work;</li> <li>• If my condition improves;</li> <li>• If I am confined in a jail, prison, penal institution, or correctional facility due to a conviction for a criminal offense;</li> <li>• If I begin to receive worker's compensation payments (or any other public benefit based on disability), or if the amount of my payment changes;</li> <li>• If my address changes.</li> <li>• If I have a claim or a settlement related to my condition(s).</li> </ul> <p><b>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 that may result in criminal prosecution and/or penalty deductions in my annuity payments.</b></p> <p><b>Signature</b><br/>(First Name, Middle Initial, Last Name) ▶</p> <div style="border: 1px solid black; width: 450px; height: 35px; margin-left: 100px;"></div> <p><b>Date</b> ▶</p> <table border="1" style="margin-left: 100px; border-collapse: collapse;"> <thead> <tr> <th style="width: 25px;">Month</th> <th style="width: 25px;">Day</th> <th style="width: 40px;">Year</th> </tr> </thead> <tbody> <tr> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 40px; height: 25px;"></td> </tr> </tbody> </table> |  |  | Month | Day | Year |  |  |  |
| Month   | Day  | Year   |  |       |     |      |  |  |  |
|   |  |  |  |       |     |      |  |  |  |
|   | <p>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.</p>  |  |  |       |     |      |  |  |  |
|   | <p><b>a. Signature of Witness</b></p>  | <p><b>b. Signature of Witness</b></p>  |  |       |     |      |  |  |  |
|   | <p>Address (Number and Street)</p>   | <p>Address (Number and Street)</p>   |  |       |     |      |  |  |  |
|   | <p>City, State/Province, and ZIP Code</p>  | <p>City, State/Province, and ZIP Code</p>  |  |       |     |      |  |  |  |
|   | <p>Daytime Telephone Number (include area code)<br/>(       )</p>  | <p>Daytime Telephone Number (include area code)<br/>(       )</p>  |  |       |     |      |  |  |  |

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**Section 12**   **How To Return Your Application**

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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 14. 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 14, 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 a month after you filed this application, please contact us so we can find out what is causing the delay.*

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## Receipt For Your Claim

| Employee Applicant's Name | 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 3:15 PM, Monday through Friday.

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### Always Report These Changes to the RRB

- **WORK** – If you work for any employer, railroad or nonrailroad, or perform any self-employment work.
  - **CONDITION** – If your condition improves.
  - **WORKER'S COMPENSATION** (or any other benefit based on disability) – If you begin to receive worker's compensation payments (or any other public benefit based on disability), or if the amount of your payment changes.
  - **CRIMINAL OFFENSE** – If you are confined in a jail, penal institution, or correctional facility due to a conviction for a criminal offense.
  - **ADDRESS** – If your address changes.
  - **LIABILITIES** – If you have a claim or a settlement related to your condition(s).
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### How To Report Changes

When a change occurs after you are entitled to disability benefits, you should report the change at once. You can make your 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:**

▶ US RAILROAD RETIREMENT BOARD  
844 N RUSH STREET  
CHICAGO IL 60611-1275

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## Important Notices

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### PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

This notice is given under the Paperwork Reduction Act of 1995 and the Privacy Act of 1974. The Privacy Act requires that the Railroad Retirement Board (RRB) tell you the following whenever we ask you for information.

- 1) The law which allows us to ask for the information;
- 2) whether that law requires you to give us that information and what, if anything, might happen to you if you do not give it to us;
- 3) the reason why the information is requested; and
- 4) the persons, organizations, and agencies to which we may release the information without your permission.

The RRB's authority for requesting this information is Section 7(b) of the Railroad Retirement Act (RRA) of 1974. Providing us with this information is voluntary on your part. However, if you fail to provide us with the requested information we may be unable to pay you any benefits. The RRB needs this information to determine whether or not you are eligible to receive such benefits and, if so, the amount you are entitled to receive. If your annuity application is approved and we begin to pay you benefits, information that we may request from you in the future will be used to determine whether you are entitled to continue to receive such benefits.

Although the information we request is almost never used for any purpose other than the payment of benefits under the RRA, the RRB does have the authority to release the following information to the indicated individuals, organizations, and/or agencies without your approval:

- 1) Information may be released to an attorney, the Office of the President, a Congressional office, a labor union or the Department of State's embassy or consular offices if they allege to be representing you at your request.
- 2) Information may be released to other people who are receiving benefits based on the same railroad retirement account as you are, if the information affects their payments from the RRB.
- 3) Information may be released to a person who will receive benefits on your behalf if the RRB decided that some medical condition keeps you from receiving your own benefits; such information may also be released in determining whether such a medical condition exists and who is suitable to receive such benefits for you.
- 4) Information (including medical records) may be released to people or organizations who are working for the RRB.
- 5) Information may be released to the U.S. Treasury Department or Postal Service to issue payments and to investigate lost, forged, or stolen payments.
- 6) Information may be released to your last employer to make sure that you are eligible to receive railroad retirement benefits and you continue to receive any available medical benefits, and to any railroad employer (or to its insurance company) to make sure that you can receive any private retirement or insurance benefits which may be offered by the employer.
- 7) Information may be released to the Social Security Administration, Centers for Medicare & Medicaid Services, Pension Benefit Guarantee Corporation, Office of Personnel Management, Department of Veterans Affairs, or Federal, State, or local welfare or public aid agencies to determine if you can receive benefits from their organizations and if any previous benefits were paid incorrectly.
- 8) Information may be released to the Internal Revenue Service or to State and local taxing authorities for figuring your taxes and for use in audits.
- 9) Your last address and the name of your last employer may be released to the Department of Health and Human Services to be used in the Parent Locator Service.
- 10) Information may be released to the Government Accountability Office for audits and for collecting overpayments owed to the RRB or Social Security Administration.
- 11) Information may be released to the U.S. Department of Labor as required by the Federal Coal Mine and Safety Act.
- 12) Information may be released in certain cases for law enforcement purposes and for court proceedings.
- 13) Information about the determination and recovery of an overpayment made to you may be released to any other person from whom any portion of the overpayment is being recovered.
- 14) Your name and address may be released to a Member of Congress to inform you about current or proposed legislation which could affect the railroad retirement system.
- 15) Information may be released to Professional Standard Review Organizations and State Licensing Boards when services provided by physicians or practitioners suggest unethical or unprofessional conduct.

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We estimate this form takes an average of 60 to 85 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 completion time, to Chief of Information Resources Management, Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois 60611-1275.

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## Computer Matching And Privacy Protection Act Notice

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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.