United States of America
Railroad Retirement Board

PROPOSED

Form Approved
OMB No. 3220-0002

Application For Determination Of Employee'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 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
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
( )

b Alternate Telephone Number
( )

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 ☐ Yes ☐ No

Additional Condition(s)	Medical Attached ☐ Yes ☐ No

When Condition Began

7 Enter the date the condition(s) ***began*** to affect your ability to work. ▶

Month	Day	Year

How Condition Affects Work

8 Enter an "X" in the appropriate box:
Have you worked since the date in Item 7? ▶

☐ Yes ▶ **Go to Item 9**
☐ No ▶ **Go to Item 10**

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.)? ▶

☐ Yes ▶ **Go to Item 9b**
☐ No ▶ **Go to Item 10**

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). ▶

Month	Day	Year

11 Describe how your condition(s) prevents you from working.

Current Work Status

12a Enter an "X" in the appropriate box:
Did you attempt to go back to work and were you unable to do so? ▶

☐ Yes ▶ **Go to Item 12b**
☐ No ▶ **Go to Section 4**

b Enter the date(s) of the work attempts.

Section 4 Information About Your Medical Care

Medical Care or Examination

13a 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 14**

Explain: _____

_____

_____

Treatment or Testing

14 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 15** ☐ No ▶ **Go to Item 16**

15 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:
Inpatient ☐ Outpatient ☐

Patient Number

Telephone Number (Include Area Code)
( )

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:
Inpatient ☐ Outpatient ☐

Patient Number

Telephone Number (Include Area Code)
( )

Dates Treated or Tested

Describe Type of Treatment or Testing

Treatment or Testing (Cont)

15c 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:

Inpatient ☐ Outpatient ☐

Patient Number

Telephone Number (Include Area Code)

( )

Dates Treated or Tested

Describe Type of Treatment or Testing

Doctor Treatment

16 Enter an "X" in the appropriate box:
Has your personal physician or other doctor treated you since the date in Item 7?

☐ Yes ▶ **Go to Item 17**

☐ No ▶ **Go to Item 18**

17 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)

17c 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

Railroad Employer Examination

18 Enter an "X" in the appropriate box:
Has your railroad employer referred you to a medical source for examination or treatment within 18 months of filing this application? ▶

❑ Yes ▶ **Go to Item 19**
❑ No ▶ **Go to Item 20**

19 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:
Inpatient ❑ Outpatient ❑

Patient Number

Telephone Number (Include Area Code)

( )

Dates Treated or Examined

Describe Type of Treatment or Examination

20 Enter an "X" in the appropriate box:
Have you been medically disqualified for work by your employer? ▶

❑ Yes ▶ **Go to Note and Item 21**
❑ No ▶ **Go to Item 21**

Note: *If answered "Yes," you must submit a copy of the Disqualification Notice.*

Activity Restriction

21 Enter an "X" in the appropriate box:
Has a medical doctor restricted your daily activities since the date in Item 7? ▶

❑ Yes ▶ **Go to Item 22**
❑ No ▶ **Go to Item 25**

22 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)

23 Enter the date the restriction began. ▶

Month | Year

Activity Restriction (Cont)

24 List and describe the condition(s) and how your daily activities were restricted by the condition(s).

Medication

25a Enter an "X" in the appropriate box:
Are you currently taking prescribed medication(s)? ▶
- ☐ Yes ▶ **Go to Item 25b**
- ☐ No ▶ **Go to Section 5**

b Enter from the prescription labels the following information for all medications prescribed for you:
Name or type of medication, dosage, and frequency. (For example, Penicillin, 1.5 gram tablet, 3 times a day.)

Name/Type	Dosage (Grams, Number of Pills, Etc.)	Frequency

Section 5 Information About Your Education And Training

Schooling

26 Enter the highest grade of school you completed. ▶

27a Enter an "X" in the appropriate box:
Are you currently attending school (including online)? ▶
- ☐ Yes ▶ **Go to Item 27b**
- ☐ No ▶ **Go to Item 28**

b Enter the date you began attending. ▶ _____ to Present

c Enter an "X" in the appropriate box:
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.

Skip Item 28 and go to Item 29b.

- ☐ Technical
- ☐ Specialized
- ☐ Vocational
- ☐ Services: _____
- ☐ Other: _____

28 Enter the date that you last attended school. ▶

Month	Day	Year

29a Enter an "X" in the appropriate box:
Have you attended technical school, or received specialized/vocational training or services? ▶
- ☐ Yes ▶ **Go to Item 29b**
- ☐ No ▶ **Go to Item 30**

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.

Type	From	To

30 Enter an "X" in the appropriate box:
Have or will you receive a degree, certificate, or license for any training you received? ▶
- ☐ Yes ▶ **Go to Item 31**
- ☐ No ▶ **Go to Section 6**

31 Enter an "X" in the appropriate box:
Is the degree, certificate, or license you received currently valid? ▶
- ☐ Yes
- ☐ No

32 Enter an "X" in the appropriate box:
Have you used any of this training in your work? ▶
- ☐ Yes ▶ **Go to Item 33**
- ☐ No ▶ **Go to Section 6**

Schooling (Cont)

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

Section 6 Information About Your Daily Activities

Activities

34 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 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	❑	❑	❑	❑	❑	▶	
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)	❑	❑	❑	❑	❑	▶	

Activities (Cont)

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

36a Enter an "X" in the appropriate box:
Do you perform any volunteer work?
(Volunteer work is any work performed without pay.)

- ☐ Yes ▶ **Go to Item 36b**
- ☐ No ▶ **Go to Item 37**

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

c Enter an "X" in the appropriate box:
Does your condition(s) restrict your ability to perform volunteer work?

- ☐ Yes ▶ **Go to Item 36d**
- ☐ No ▶ **Go to Item 37**

d Describe the changes.

37a Enter an "X" in the appropriate box:
Do you participate in social or recreational activities?
For example, clubs, traveling, exercise, indoor/outdoor sports, hobbies/crafts, etc.

- ☐ Yes ▶ **Go to Item 37b**
- ☐ 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 Enter an "X" in the appropriate box:
Does your condition(s) restrict your participation in the activities listed above?

- ☐ Yes ▶ **Go to Item 37d**
- ☐ No ▶ **Go to Section 7**

d Describe the changes.

Section 7 Information About Your Work And Earnings

Work for an Employer Last 12 Months

38 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 39**
❑ No ▶ **Go to Item 40**

39 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

40 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

41 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 42**
❑ No ▶ **Go to Section 8**

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

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

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

Section 8 General Information

Filing AA-1

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

❑ Yes ▶ **Go to Item 52**
❑ No ▶ **Go to Item 46**

Self-Employment

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

❑ Yes ▶ **Go to Note and Item 47**
❑ No ▶ **Go to Item 48**

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

Self-Employment (Cont)

47 Enter an "X" in the appropriate box:
Are you a corporate officer or owner/operator of a corporation? ▶
- ☐ Yes ▶ **Go to Note and Item 48**
- ☐ No ▶ **Go to Item 48**

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

48 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 49**
- ☐ No ▶ **Go to Item 49**

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

Public Disability Benefits

49 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 50**
- ☐ No ▶ **Go to Item 50**

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

Social Security Benefits

50 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 51**
- ☐ No ▶ **Go to Item 52**

51 Enter the social security claim number under which you have filed or will file. ▶

Criminal Offenses

52 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 53**
- ☐ No ▶ **Go to Section 9**

53 Enter the date of the conviction. ▶

Month	Day	Year

54 Enter an "X" in the appropriate box:
Is your disability related to the commission of the criminal offense? ▶
- ☐ Yes
- ☐ No

55 Enter the date of the sentence of confinement. ▶

Month	Day	Year

56 Enter the date that confinement began. ▶

Month	Day	Year

57 Enter an "X" in the appropriate box:
Is your disability related to your confinement? ▶
- ☐ Yes
- ☐ No

58 Enter an "X" in the appropriate box:
Has the confinement ended? ▶
- ☐ Yes ▶ **Go to Item 59**
- ☐ No ▶ **Go to Section 9**

59 Enter the date confinement ended. ▶

Month	Day	Year

Section 9 Remarks

Remarks

60 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 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

61a Did you complete this application with the assistance of an attorney or non-family member (RRB staff excluded)? ▶
- ☐ Yes ▶ **Go to Item 61b**
- ☐ No ▶ **Go to Item 62**

b Enter the name and address of the attorney or non-family member who assisted with completing this application. ▶

c Did you pay a fee to the attorney or non-family member who assisted with completing this application? ▶
- ☐ Yes
- ☐ No

62 Enter an "X" in the appropriate box:
Will you have a guardian or other representative sign this application on your behalf? ▶
- ☐ Yes ▶ **Go to Note and Item 63**
- ☐ No ▶ **Go to Item 63**

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

63 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, ***RB-1d, Employee Disability Benefits,*** and ***RB-9, Employee and Spouse Annuities Events That Must Be Reported.*** I understand that I am responsible for reporting events that would affect my annuity as explained in the booklets.

I agree to immediately notify the RRB:
- If I 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 I begin to receive worker's compensation payments (or any other public benefit based on disability), or if the amount of my payment changes;
- If my address changes.
- If I have a claim or a settlement related to my condition(s).

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.

Signature (First Name, Middle Initial, Last Name) ▶

Date ▶ Month | Day | Year

64 If this certification is signed by mark ("X") in Item 63, two witnesses who know the person signing must sign below, giving their full addresses and daytime telephone numbers.

a. Signature of Witness	**b. Signature of Witness**
Address (Number and Street)	Address (Number and Street)
City, State/Province, and ZIP Code	City, State/Province, and ZIP Code
Daytime Telephone Number (include area code) ( )	Daytime Telephone Number (include area code) ( )

Section 12 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 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.*

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. Offices are open to the public 9:00 AM to 3:30 PM daily, except Wednesday 9:00 AM to 12:00 PM and closed Federal Holidays.

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'scompensation 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).

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

Important Notices

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.

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.

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.