

# CURRENT

## RIGHTS REQUEST FORM

Billing Document ID:  
Overpayment Amount:  
Letter Date:  
Employee's Name:  
Your Name:  
Full Address:

Daytime Phone:  
**(Please enter any missing information or correct any errors.)**

### YOUR REQUEST CHOICES *(Place an "X" opposite your request choice)*

\_\_\_ REVIEW OF THE FACTS ONLY

\_\_\_ WAIVER ONLY

**(Waiver requests made at any time will be accepted. However, if the request is not received within 60 days, any amounts collected prior to the request will not be waived.)**

\_\_\_ BOTH REVIEW OF THE FACTS AND WAIVER

\_\_\_ PERSONAL CONFERENCE

**(If you wish to request a personal conference, you must also make a request for a review of the facts and/or waiver.)**

Your remarks: *(Use the back of this form if necessary.)*

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If you wish to request your rights, sign this form and return it in the enclosed self-addressed return envelope to:

Railroad Retirement Board  
Retirement Survivor Debt Collections  
PO Box 979018  
St. Louis MO 63197-9000

Your Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

For RRB Use Only: { }