

FACSIMILE: APPL - RSDHI CLAIMS APPLICATION

MCS TRANSFER TO: XXXX RSDHI CLAIMS APPLICATION

**APPL**

[1-M]

NH NAME: XXX  
XX

[2-M]

[3-M]

SSN: SSSSSSSSS SEX: X NH BIRTHDATE: 99999999

[4-M]

[5-C]

PROOF (A/B/C/F/Q): X PROOF TYPE (P/H/N/O): X

[6-M]

SELECT CLAIM TYPE(S): 9 9 9 1. RETIREMENT 4. AUXILIARY 7. AGE 72  
2. DISABILITY 5. UNINS MED ONLY 8. ESRD

[7-C]

3. SURVIVOR 6. LUMP SUM

ABBREVIATED APPLICATION: X

CLAIMANT (IF DIFFERENT)

[8-C]

NAME: XXX  
XXXX

[9-C]

[10-C]

[11-C]

SSN: 999999999 SEX: X BIRTHDATE: 99999999

[12-C]

[13-C]

PROOF (A/B/C/F/Q): X PROOF TYPE (P/H/N/O): X

[14-C]

[15-C]

RELATIONSHIP TO NH: 9 1. SPOUSE (SUBSEQUENT CLAIM: 9 ) 1. RIB  
2. SPOUSE WITH CHILD IN CARE 2. DIB  
3. CHILD

APPLICANT (IF DIFFERENT) 4. DEPENDENT PARENT

[16-C]

NAME:

XX

[17-C]

[18-C]

[19-C]

SSN: 999999999 EIN: 999999999 WILL APPLICANT BE ENTERED IN RPS (Y/N):

X

FACSIMILE: ADDB - ADDITIONAL BENEFITS

mcs TRANSFER TO: XXXX ADDITIONAL BENEFITS **ADDB**  
NH SSSSSSSSS SSSSS SSSSSSSSSS CL SSSSSSSSS SSSSS  
SSSSSSSSSS

[1-M]

ACTIVE U.S. MILITARY/RESERVE/NATL GUARD SERVICE AFTER SEPT 7 1939  
(Y/N): X

[2-M]

[3-C]

WORKED IN RR FOR 5 YEARS OR MORE (Y/N): X SPOUSE (Y/N): X

[4-M]

[5-C]

RECEIVING RR RETIREMENT PENSION/ANNUITY (Y/N): X SPOUSE (Y/N): X

[6-M]

[7-C]

COVERED UNDER FOREIGN SSA (Y/N): X COUNTRY: XXXXXXXXXXXX IF  
COVERED

[8-C]

[9-C]

FILING FOR FOREIGN SSA (Y/N): X REQUIRES FOREIGN QC'S FOR US  
FILING (Y/N): X

[10-C]

[11-C]

SPOUSE COVERED UNDER SSA OF OTHER COUNTRY (Y/N): X COUNTRY:  
XXXXXXXXXX

[12-M]

[13-C]

CIVILIAN EMPLOYEE OF FEDERAL GOVT IN JAN 1983 (Y/N): X SPOUSE (Y/N):  
X

[14-M]

[15-C]

JAPANESE INTERNEE (Y/N): X VOW OF POVERTY (Y/N):

[16-M]

QUALIFY FOR US FED/STATE/LOCAL GOVT PENSION BASED ON ANY WORK  
YOU PERFORMED

which was NOT COVERED UNDER SSA (Y/N): x

[17-M]

CURRENTLY ENTITLED TO A PENSION NOT COVERED UNDER SSA (Y/N): X

[18-C]

IF NO, DO YOU EXPECT TO BE ENTITLED TO A PENSION NOT COVERED UNDER  
SSA IN THE FUTURE

(Y/N): X

[19-C]

IF YES, SHOW FUTURE ENTITLEMENT DATE (MMYY): 9999

[20-M]

CLAIMANT HAS CHILD OF NH IN CARE (Y/N): X

[21-C]

FILING FOR MEDICARE ONLY, RESTRICTING MONTHLY BENEFITS (Y/N): X

[22-C]

WILL MEDICARE APPLY: 9 1. YES 2. NO 3. ALREADY ENROLLED ON ANOTHER  
SSN

[23-M]

IF CLAIMANT IS FILING AS A SURVIVING SPOUSE, IS CLAIMANT

FILING FOR BENEFITS ON OWN RECORD (Y/N): X



FACSIMILE: CLMR - CL MILITARY RETIREMENT/FEDERAL BENEFIT  
MCS 2.5 TRANSFER TO: XXXX CL MILITARY RETIREMENT/FEDERAL  
BENEFIT **CLMR**

NH SSSSSSSSSS SSSSS SSSSSSSSSSS CL SSSSSSSSSS SSSSS  
SSSSSSSSSS

[\[1-C\]](#)

IF RETIRED FROM MILITARY, BASIS OF RETIREMENT: 9

- 1. LENGTH OF SERVICE                      3. RESERVE SERVICE PAYABLE AT AGE 60
- 2. DISABILITY                                4. OTHER

[\[2-C\]](#)

IF OPTION 4 CHOSEN, EXPLAIN: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

[\[3-C\]](#)

IF RETIRED AND SERVICE AFTER DEC 31, 1956, INDICATE BRANCH OF  
SERVICE PAYING

BENEFIT: 9

- 1. ARMY                                        5. COAST GUARD
- 2. NAVY                                        6. PUBLIC HEALTH SERVICE
- 3. AIR FORCE                                7. COASTAL/GEODETIC SURVEY
- 4. MARINE CORPS                        8. OTHER

[\[4-C\]](#)

IF OPTION 8 CHOSEN, EXPLAIN: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

[\[5-C\]](#)

WAIVED ALL/PART OF RETIREMENT TO GET VA OR OTHER FED CREDIT (Y/N):  
X

[\[6-C\]](#)

IF ELIGIBLE FOR CIVILIAN FEDERAL AGENCY BENEFITS, INDICATE BENEFIT  
TYPE: 9

- 1. SERVICE 2. SURVIVOR 3. DISABILITY 4. OTHER

[\[7-C\]](#)

IF OPTION 4 CHOSEN, EXPLAIN: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

[\[8-C\]](#)

NAME OF FED AGENCY:  
XX

[\[9-C\]](#)

[\[10-C\]](#)

[\[11-C\]](#)

YEARS EMPLOYED: 99 DATE CLAIM FILED: 999999 CLAIM NO.:  
XXX999999999

[\[12-C\]](#)

MOST RECENT AGENCY:  
XX

[\[13-C\]](#)

[\[14-C\]](#)

[\[15-C\]](#)

CITY: XXXXXXXXXXXXX STATE: XX LAST WORKED: 999999

FACSIMILE: CLMS - CL MILITARY SERVICE PAGE 1

MCS

CL MILITARY SERVICE

CLMS

NH: SSSSSSSSS SSSSS SSSSSSSSSSS  
SSSSSSSSSS

CL: SSSSSSSSS SSSSS

[1-C]

[2-C] [3-C]

FIRST NAME USED IN SERVICE: XXXXXXXXXXXX MI: X LAST NAME:  
XXXXXXXXXXXXXXXXXXXX

[4-C]

SERVICE NO: XXXXXXXXXX

[5-M]

\*RECEIVE OR ELIGIBLE FOR MIL OR CIV FEDERAL AGENCY BENEFIT (SELECT ONE): x

1=CIVILIAN 2=MILITARY 3=BOTH 4=NONE.

[6-C] [7-C]

[8-C]

[9-C]

[10-C]

[11-C]

[12-C]

[A/R]	BRANCH OF SERVICE	START	END	N/E	RANK	PROOF
X	XXXXXXXXXXXXXXXXXX	999999	999999	X	XXXXXXXXXXXXXXXXXX	XXX
X	XXXXXXXXXXXXXXXXXX	999999	999999	X	XXXXXXXXXXXXXXXXXX	XXX
X	XXXXXXXXXXXXXXXXXX	999999	999999	X	XXXXXXXXXXXXXXXXXX	XXX
X	XXXXXXXXXXXXXXXXXX	999999	999999	X	XXXXXXXXXXXXXXXXXX	XXX
X	XXXXXXXXXXXXXXXXXX	999999	999999	X	XXXXXXXXXXXXXXXXXX	XXX
X	XXXXXXXXXXXXXXXXXX	999999	999999	X	XXXXXXXXXXXXXXXXXX	XXX
X	XXXXXXXXXXXXXXXXXX	999999	999999	X	XXXXXXXXXXXXXXXXXX	XXX
X	XXXXXXXXXXXXXXXXXX	999999	999999	X	XXXXXXXXXXXXXXXXXX	XXX
X	XXXXXXXXXXXXXXXXXX	999999	999999	X	XXXXXXXXXXXXXXXXXX	XXX
X	XXXXXXXXXXXXXXXXXX	999999	999999	X	XXXXXXXXXXXXXXXXXX	XXX

[13-C] [14-C]

[15-C]

[16-C]

[JAPANESE INTERNEE]	START	END	PROOF	HOURLY WAGE
	999999	999999	X	99999999
	999999	999999	X	99999999

[17-C]

PF1 FOR HELP MORE (Y/N): X

PAGE: 1

TRANSFER TO: XXXX







FACSIMILE: DISB - DISABILITY INFORMATION

TRANSFER TO: XXXX      DISABILITY INFORMATION      **DISB**

NH SSSSSSSSS    SSSSS SSSSSSSSSSS    CL SSSSSSSSS    SSSSS  
SSSSSSSSSS

[\[1-M\]](#)

DISABLING

CONDITION:XX  
XXXXXXXXXX

[\[2-M\]](#)

[\[3-C\]](#)

STILL DISABLED (Y/N): X    IF NO, DATE DISABILITY ENDED (MMYY): 9999

[\[4-M\]](#)

[\[5-M\]](#)

BLIND (Y/N): X      FREEZE (Y/N): X

[\[6-M\]](#)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (Y/N): X

[\[7-M\]](#)

FILED OR INTEND TO FILE FOR: 9 9 9    1. VA 2. WC/Public disability Benefits  
3. NOT FILING

[\[8-M\]](#)

[\[9-C\]](#)

DISABILITY WORK RELATED (Y/N):X REASON NOT FILING:  
XXXXXXXXXXXXXXXXXXXXXXXXXXXX

[\[10-M\]](#)

[\[11-C\]](#)

MONEY FROM EMPLOYER AFTER ONSET DATE (Y/N): X      AMOUNT: 99999999

[\[12-C\]](#)

TYPE: XXX

[\[13-M\]](#)

[\[14-C\]](#)

ADDITIONAL MONEY EXPECTED FROM EMPLOYER (Y/N): X      AMOUNT:  
99999999

[\[15-C\]](#)

TYPE: XXX

[\[16-M\]](#)

[\[17-C\]](#)

NUMBER OF CHILD CARE YRS: 9    ACTUAL CHILD CARE YRS: 99 99 99 99 99 99  
IF PARENT RECEIVED 1/2 SUPPORT AT TIME OF ONSET OF DISABILITY  
COMPLETE

[\[18-C\]](#)

NAME: XXXXXXXXXXX X XXXXXXXXXXXXXXXXXXXXXXX

[\[19-C\]](#)

ADDRESS:

XX  
XX

[\[20-C\]](#)

NAME: XXXXXXXXXXX X XXXXXXXXXXXXXXXXXXXXXXX

[\[21-C\]](#)

ADDRESS:

XX  
XX

FILED OR INTEND TO FILE FOR OTHER DISABILITY (Y/N): S

SPECIFY:SSSSSSSSSSSSSS

FACSIMILE: EARN - EARNINGS

MCS

EARNINGS

**EARN**

NH SSSSSSSSSS SSSSS SSSSSSSSSSS  
SSSSSSSSSS

CL SSSSSSSSSS SSSSS

LIST ALL EARNINGS AND TYPES FOR SSSS SSSS SSSS

EARNINGS TYPES ARE:1=FICA WAGES 2=SEI 3=EMPLOYEE REPORTED TIPS  
4=RR LAG.

PROOF CODES ARE: P=PROVEN R=READILY AVAILABLE N=NOT AVAILABLE  
D=DELETED LAG.

[EARNINGS	[1-C]	[2-C]	[3-C]	[4-C]	PROOF
	YEAR	TYPE	AMOUNT		
	99	9	9999999.99	X	
	99	9	9999999.99	X	
	99	9	9999999.99	X	
	99	9	9999999.99	X	
	99	9	9999999.99	X	
	99	9	9999999.99	X	
	99	9	9999999.99	X	
	99	9	9999999.99	X	
	99	9	9999999.99	X	
	99	9	9999999.99	X	
	99	9	9999999.99	X	
	99	9	9999999.99	X	
	99	9	9999999.99	X	

[5-C]

COMPUTE BENEFITS AND COMPLETE CLAIM WITHOUT LAG EARNINGS (Y/N): X  
TRANSFER TO :XXXX