United States of America

CURRENT

Form Approved
OMB No. 3220-0052

	RRB Claim Number:		
Statement Regarding	Employee's SS Number:		
Patient's Capability	Employee's Name:		
to Manage Benefits	Beneficiary's SS Number:		
	Beneficiary's Name:		
Physician/Medical Officer Name, Address, and Telephone Number		RRB Information	
-		Office Number:	
		Date Released:	
		U. S. RAILROAD RETIREMENT BOARD	
Telephone Number:			

## **Paperwork Reduction Act and Privacy Act Notices**

This report is authorized by Section 7 of the Railroad Retirement Act, as amended (45 U.S.C. 231f). While you are not required to respond, your cooperation will help us decide whether any railroad retirement benefits that may be due should be paid directly to the patient or to someone else on the patient's behalf. Although we cannot reimburse you for your services, your cooperation in completing and returning this statement will be appreciated. Please answer all items as completely as possible. If you need more space, you may use Item 8 for this purpose. For your convenience we have enclosed an envelope requiring no postage.

We estimate this form takes an average of 6 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 Associate Chief Information Officer for Policy & Compliance, Railroad Retirement Board, 844 N. Rush St., Chicago, Illinois 60611-1275.

Patient Name and Address					
1.					
Physician's Statement					
2.	Provide the date examination.	of your most red	cent	3. In your opinion, is the patient able to manage benefit payments in	Yes Go to Item 9
	Month	Day	Year	the patient's best interest?	☐ No Go to Item 4
<b>NOTE:</b> The ability to manage benefit payments in the patient's best interest is the ability to understand and act on the ordinary affairs of life, such as providing for one's own adequate food, housing, clothing, etc., and the ability, in spite of physical impairment, to manage funds. The physical ability to endorse checks is not sufficient to indicate the ability to manage benefit payments.					
4.	Do you expect th to handle benefit interest?	•	•	□ No	ate of recovery
				Undetermined	

<ol> <li>Describe the medical condition(s) which impair(s) the patient's ability to manage benefit payments.</li> <li>If you need additional space, continue in Item 8.</li> </ol>				
6. Has anyone assumed responsibility for the patient's welfare?	Yes Go to Item 7 No Go to Item 9			
7. Name	Number and Street, P.O. Box, or Rural Route			
City and State	ZIP Code			
Area Code Telephone Number				
Relationship to patient:    Spouse   Relative   Legal Guardian   Other      8. Remarks	Specify relationship  Specify			
9. Certification				
I certify that the information I have given is true, compl penalties may be imposed on me for false or fraudulen	ete, and correct. I understand that criminal or civil it statements.			
Physician's/Medical Officer's Signature	Date			
Physician's/Medical Officer's Name and Title (Please Print)				