United States of America
Railroad Retirement Board

CURRENT

Form Approved
OMB No. 3220-0155

SUPPLEMENT TO CLAIM OF PERSON OUTSIDE THE UNITED STATES

Railroad Retirement Claim Number

Railroad Employee's Social Security Number

Railroad Employee's Name

PAPERWORK REDUCTION ACT and PRIVACY ACT NOTICES

This notice is given under both the Paperwork Reduction Act of 1995 and the Privacy Act of 1974. The information requested in this form is used to determine whether your country of residence or your citizenship status will affect your Railroad Retirement Act benefits. The Railroad Retirement Board's authority for requesting this information is Section 7b(6) of the Railroad Retirement Act.

Providing the requested information is voluntary, except as noted below. However, if you fail to provide us with such information, we will be unable to pay you any benefits. Moreover, your obligation to provide us with the above information becomes mandatory when your refusal to disclose this information reflects a fraudulent intent to obtain benefits not authorized by law. Under these circumstances, your refusal to provide us with this information may be punishable by fine or imprisonment, or both.

We estimate this form takes an average of 10 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 and Compliance, Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois 60611-1275.

INSTRUCTIONS: This form is to be completed by or on behalf of a person who is, or will be outside the United States for 30 days or more. A person is considered outside the United States if physically outside the 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa. If additional space is needed use Item 8, Remarks.

1. List below the full name of each beneficiary in the same household who is, or will be outside the U.S.

	Country of Birth	Country of Residence		Country(ies) of Present Citizenship (or at time of death)	If Person Has U.S. Passport, list:	
		Present	Over Next 12 Months		Passport No.	Date Issued
(a)						
(b)						
(c)						

NOTE: All persons listed above or their representative payees must sign the certificate on the reverse side of this form (Item 9).

2. If any beneficiary listed in Item 1, above, was outside the U.S. this month or any of the past 18 months, or will be in the next 6 months, complete Item 2 by entering the name of the beneficiary and the dates (month and year) he/she was or will be outside the U.S.

Name	Outside U.S.		Outside U.S.		Date of Expected Return to U.S. (if within the next 6 months)
	From	To	From	To	
(a)					
(b)					
(c)					

3. Has any person listed in Items 1 or 2, above, been employed or self-employed outside the U.S. in the past 12 months? If "Yes," give name and date(s) work began. ☐ YES ☐ NO

Name	Date(s)

4. Does any person listed in Items 1 or 2, above, expect to begin employment or self-employment outside the U.S. in the future? If "Yes," give name and date(s) work is expected to begin. ☐ YES ☐ NO

Name	Date(s)

(Continued)

5. List Below the Full Name of Each Beneficiary Listed In Item 1	Total Number of Years Lived in the U.S.	Relationship to Railroad Employee During this Period	Dates Person Resided in the U.S.			
			From	To	From	To
			Month/Year	Month/Year	Month/Year	Month/Year
(a)						
(b)						
(c)						

NOTE: If additional space is needed use Item 8, Remarks.

6. **Answer only if the railroad employee is deceased**. Did the railroad employee die while in the military service of the U.S. or as a result of disease or injury incurred or aggravated in the military service? ☐ YES ☐ NO

7. Medicare medical insurance (Part B) generally is payable only for medical services provided inside the U.S. If anyone listed in Item 1 is now enrolled in Medicare medical insurance (Part B) and wishes to terminate Part B enrollment, enter their name here.

Name	Name

8. Remarks (Use this space for additional comments and explanations. If you need more space, attach a separate sheet.)

CERTIFICATION

I agree to notify the Railroad Retirement Board promptly if I (or any person for whom I receive benefits) become employed or self-employed while outside the U.S., change citizenship, or go (for more than 30 days) into any country other than that indicated in Item 9e.

I certify that all the information I have provided in completing this form is true to the best of my knowledge. I know that, if I have made a false or fraudulent statement on this form, or if my refusal to provide this information reflects a fraudulent intent to obtain benefits not authorized by law, I am committing a crime which is punishable under Federal law by fine or imprisonment, or both.

9. (a) **Signature** (First Name, Middle Initial, and Last Name) of Each Person Listed in Item 1. **Representative Payees Must Sign for Minors and for Incapable or Incompetent Adults.** (**Write in Ink**)	(b) Date	(c) Telephone Number Where You May Be Contacted During the Day
(1)		
(2)		
(3)		

(d) **Address** (Where checks should be mailed while you are abroad)

Number and Street	City	Postal Code	Country

NOTE: If more than one mailing address is required, use Item 8, Remarks, and show names for each address.

(e) **Residence Abroad** (If checks are sent to a bank or Post Office Box or if your check mailing address is not your residence, provide your residential address)

Name	Number and Street	City	Postal Code	Country
(1)				
(2)				
(3)				

Explain in Item 8, Remarks, why checks cannot be sent to your residence. If you use an APO/FPO address, explain why you do not have a residential address.

10. If this application has been signed by mark (X) in Item 9, two witnesses who know the signer(s) must sign below, giving their full addresses.

(a) Signature of Witness			(b) Signature of Witness		
Address (Number and Street)			Address (Number and Street)		
City	Postal Code	Country	City	Postal Code	Country