UNITED STATES OF AMERICA
RAILROAD RETIREMENT BOARD

Proposed

FORM APPROVED
O.M.B. No. 3220-0030

APPLICATION FOR DETERMINATION OF WIDOW(ER)'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-17b, Widow(er)'s Disability Benefits**, which explains information you will need to answer many of the questions in this application. Please read "Important Notices" on page 12 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 December 13, 2024, as:

Month	Day	Year
12	13	2024

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 6 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 SOCIAL SECURITY NUMBER →	
	3		EMPLOYEE'S RAILROAD RETIREMENT CLAIM NUMBER →	
Applicant Identification	4		APPLICANT'S NAME →	
	5	a	APPLICANT'S STREET ADDRESS →	
		b	CITY AND STATE/ PROVINCE →	
		c	ZIP CODE →	
		d	COUNTRY →	
	6	a	DAYTIME TELEPHONE NUMBER →	
		b	ALTERNATE TELEPHONE NUMBER →	

Section 3 Information About Your Medical Condition

Medical Condition

7 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

8 Enter the date the condition ***began*** to affect your ability to work. → Month | Day | Year

How Condition Affects Work

9 Enter an "X" in the appropriate box:
Have you worked since the date in Item 8? →
❑ Yes → **Go to Item 10**
❑ No → **Go to Item 12**

10 Enter an "X" in the appropriate box:
Has your condition caused you to change:

	Yes	No
Your job duties? →	❑	❑
Your hours of work? →	❑	❑
Your attendance? →	❑	❑
Anything else about your work? →	❑	❑
	If "Yes" to any item, go to Item 11	**If "No" to all items, go to Item 12**

11 Explain what the changes in your work circumstances were, the dates they occurred, and why your condition made these changes necessary.

CHANGES	DATES	CONDITION

When Unable to Work

12 Enter the date you could no longer work because of your condition(s). → Month | Day | Year

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

Current Work Status

14 a 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 14b**
❑ 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

15 a Enter an "X" in the appropriate box:
Have you received medical care or been examined for my condition since the date in Item 8. →
❑ Yes
❑ No

b Enter an "X" in the appropriate box:
Are you scheduled for any additional medical care for your conditions(s) (i.e. surgeries, etc.) ***after*** you file this application? ▶
❑ Yes **Explain below**
❑ No **Go to item 16**

Explain: _____

Treatment or Testing

16 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 17**
❑ No ⟶ **Go to Item 18**

17 Enter information about each hospital, institution, or clinic where you have received treatment or care since the date in Item 8.

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	Area Code / Telephone Number
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	Area Code / Telephone Number
Dates Treated or Tested	Describe Type of Treatment or Testing

c

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	Area Code / Telephone Number
Dates Treated or Tested	Describe Type of Treatment or Testing

Doctor Treatment

18 Enter an "X" in the appropriate box:
Has your personal physician or other doctor treated you since the date in Item 8? ⟶

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

Doctor Treatment (Continued)

19 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	Area Code / Telephone Number
Dates Treated or Examined	Describe Type of Treatment or Testing

b

Name of Physician	Address of Facility (Street Address, City, State/Province and Zip Code)
Patient Number	Area Code / Telephone Number
Dates Treated or Examined	Describe Type of Treatment or Testing

c

Name of Physician	Address of Facility (Street Address, City, State/Province and Zip Code)
Patient Number	Area Code / Telephone Number
Dates Treated or Examined	Describe Type of Treatment or Testing

Activity Restriction

20 Enter an "X" in the appropriate box:
Has a medical doctor restricted your daily activities since the date in Item 8? ⟶

- ❑ Yes ⟶ **Go to Item 21**
- ❑ No ⟶ **Go to Item 24**

21 Enter the name of the medical doctor who imposed the restriction. Also enter the medical doctor's address if it has not been previously entered in items 17 or 19.

Name of Medical Doctor	Address of Medical Doctor (Street Address, City, State/Province and Zip Code)

Activity Restriction (Continued)	22	Enter the date the restriction began. →	MONTH	YEAR
	23	List and describe the condition(s) and how your daily activities were restricted by the condition(s).		
Medication	24	Enter an "X" in the appropriate box: Are you currently taking prescribed medication(s). →	❑ Yes → **Go to Item 25** ❑ No → **Go to Section 5**	
	25	Enter from the prescription labels the following infomation 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. →		
	27 a	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	
	29 a	Enter an "X" in the appropriate box: Have you attended a technical school, or received specialized/vocational training or service? →	❑ Yes → **Go to Item 29b** ❑ No → **Go to Item 30**	
	b	Describe the type of technical school you attedned, 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 → **Go to Item 32** ❑ No → **Go to Section 6**	
	32	Enter an "X"in the appropriate box: Have you used any of the training in your work? →	❑ Yes → **Go to Item 33** ❑ No → **Go to Section 6**	

Section 6 Information About Your Daily Activities

Daily Activities

33 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 or without 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	❑	❑	❑	❑	❑ →	
Sleeping	❑	❑	❑	❑	❑ →	
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)	❑	❑	❑	❑	❑ →	

Daily Activities (Continued)	34	a	Describe your daily activities during a normal day (i.e., typical day form the time you get up until you go to bed.)	
		b	Describe and explain if your condition affects you memory, concentration, or ability to understand and follow instructions. (Include when this change began.)	
	35	a	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 35b** ❑ No ⟶ **Go to Item 36**
		b	Describe the volunteer work you perform and enter the average number of 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 35b** ❑ No ⟶ **Go to Item 36**
		d	Describe the changes.	
	36	a	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 36b** ❑ No ⟶ **Go to Section 7**
		b	Describe the social or recreational activities that you participate in, and enter the averager number of 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 36d** ❑ No ⟶ **Go to Section 7**
		d	Describe the changes.	

Section 7 Information about your Work and Earnings

Work Activitiies — 37

Enter an "X" in the appropriate box:
Have you ever been employed or self-employed? →

- ☐ Yes → **Go to Note and Item 38**
- ☐ No → **Go to Section 8**

Note: *If you answered "Yes"* ***and*** *you are a widow(er) filing a* ***disability annuity*** *also complete and return to the RRB* ***Form G-251, Vocational Report***

Work for an Employer — 38

Enter an "X" in the appropriate box:
Have you worked for pay for an employer in the last 12 months? (Do not include any self-employment.) →

- ☐ Yes → **Go to Item 39**
- ☐ No → **Go to Item 41**

This Calendar Year — 39

Enter your earnings, before any deduction, 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

Last 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

Self-Employment — 41

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

- ☐ Yes → **Go to Note and Item 42**
- ☐ No → **Go to Item 44**

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

This Calendar Year — 42

Enter your **net** earnings for each month you have already worked ***this year.*** Then, starting with the current month, enter your expected earnings for this month and each remaining month ***this year***.

JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE

JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER

Last Calendar Year — 43

Enter your **net** 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 — 44

Enter an "X" in the appopriate box:
Do you expect to work during the next 12 months? (Include self-employment, if any.) →

- ☐ Yes → **Go to Item 45**
- ☐ No → **Go to Section 8**

Work Next 12 Months Continued	45	Enter the name and address of the person or company for whom you expect to work. (if self-employed, enter "Self".) →	
	46	Enter the date(s) you expect to work. (For example, "June and July," "Indefinitely Starting 12-2024," etc.) →	
	47	Enter the gross amount you expect to earn. (If you are self-employed, enter the **net** amount →	

Section 8 General Information

Filing AA-17 or AA-18	48	Enter an "X" in the appropriate box: Are you filing either **Form AA-17** or **Form AA -18** at this time? →	☐ Yes → **Go to Item 54** ☐ No → **Go to Item 49**
Social Security Benefits	49	Enter an "X" in the appropriate box: Have you filed , or expect to file, for monthly Social Security disability benefits? →	☐ Yes → **Go to Item 50** ☐ No → **Go to Item 51**
	50	Enter the Social Security claim number under which you have filed or will file.	
Public Service Pension	51	Enter an"X" in the appropriate box: Are you receiving or do you expect to receive a pension or have you received or do you expect to receive a lump-sum payment instead of a pension based on your earnings from an agency of the Federal, state, or local government? (Answer "NO" if your only government pension payments are social security, railroad retirement, veterans affairs, worker's compensation, or black lung benefits. Also answer "NO" if you received a lump-sum payment that was just your contributions to the pension fund plus interest. →	☐ Yes → **Go to Item 52** ☐ No → **Go to Item 54**
	52	Are you or were you an employee of the Federal Government?.	☐ Yes → **Go to Note and Item 54** ☐ No → **Go to Item 53**
		Note: *If you answer "Yes," also complete and return the RRB **Form G-208, Public Service Pension Questionaire**, and verification of your pension.*	
	53	Enter an "X" in the appropriate box: On your last day of employment, were you employed by a state or local government or the military service and social security (FICA) taxes were bieng deducted from my public service earnings?	☐ Yes → **Go to Item 54** ☐ No → **Go to Note and Item 54**
		Note: *If you answer "No," also complete and return the RRB **Form G-208, Public Service Pension Questionaire**, and verification of your pension.*	
Criminal Offense	54	Enter an "X" in the box: Within the past 12 months were you imprisoned or given a sentence of confinement due to a conviction for a criminal offense? →	☐ Yes → **Go to Item 55** ☐ No → **Go to Section 9**
	55	Enter the date of the conviction. →	Month | Day | Year
	56	Is your disability related to the commission of the criminal offense? →	☐ Yes ☐ No

Criminal Offense Continued					
	57	Enter the date of the sentence of confinement. →		Month / Day / Year	
	58	Enter the date that confinement began. →		Month / Day / Year	
	59	Enter an "X" in the appropriate box: Is your disability related to your confinement? →	❑ Yes ❑ No		
	60	Enter an "X" in the appropriate box: Has the confinement ended? →	❑ Yes → **Go to Item 61** ❑ No → **Go to Section 9**		
	61	Enter the date confinement ended. →		Month / Day / Year	

Section 9 Remarks

Remarks	62	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 Certification

Certification

63	a	Did you complete this application with the assistance of an attorney or non-family member (RRB staff excluded)? →	☐ Yes → **Go to Item 63b** ☐ No → **Go to Item 64**
	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 appication? →	☐ Yes ☐ No
64		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** ☐ No → **Go to Item 65**

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

65 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 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 recevied and reviewed the booklet, **RB-17b, Widow(er)'s Disability Benefits**. I understand that I am responsible for reporting events that would affect my annuity as explained in the booklet.

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, or prison, penal institution, or correctional facility due to a conviction for a criminal offense;
- If my address changes;
- If I remarry;
- If I file for social sercurity benefits based on ***any*** person's earning record; or
- If I begin to receive a pension from an agency of the Federal, state, or local government of if my present payment changes

I know that if I am receiving a disability annuity and fail to report work and earnings promtly, I am committing a crime punishable by Federal law that may result in prosecution and/or penalty deductions in my annuity payments.

Signature →

(First Name, Middle Initial, Last Name)

Date →

Month	Day	Year

66 If this certification is signed by mark (X) in Item 65, two witnesses who know the person signing must sign below, giving their full address and daytime telephone number.

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 11 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 13 of this application. 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 13, 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 two weeks after you filed this application, please contact us so we can find out what is causing the delay.*

Important Notices

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

The information asked for in this form is needed to determine your entitlement to benefits under the Railroad Retirement Act. The RRB's authority for requesting this information is Section 7(b)(6) of the Railroad Retirement Act.

We estimate that this form takes and average of 40 to 50 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 the completion time, to: the Associate Chief Information Officer for Policy and Compliance, Railroad Retirement Board, 844 North Rush Street, Chicago, IL 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.

Receipt For Your Claim

EMPLOYEE'S NAME		
APPLICANT'S NAME	RAILROAD RETIREMENT BOARD CLAIM NUMBER	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 from 9:00 a.m. to 3:00 p.m., Monday through Friday and closed Federal holidays.

Always Report These Changes To The RRB

- **Address** — If your address changes.
- **Work** — If you perform work for any employer, railroad or nonrailroad, or perform any self-employment work.
- **Remarriage** — If you remarry.
- **Condition** — If your condition improves.
- **Social Security** — If you file for benefits on ***any*** person's earnings.
- **Criminal Offense** — If you are confined in a jail, prison, penal institution, or correctional facility due to a conviction for a criminal offense.
- **Public Service Pension** — If you begin to receive a pension from an agency of the Federal, state, or local government or if your present payments change.

How To Report Changes

When a change occurs after you become entitled to disability benefits, it should be reported the change at once. You or your representative can make the reports by telephone, mail, or in person, whichever you prefer.

To report any of the above changes, contact:

▶

☎ Telephone Number: **(877) 772-5772**

If for some reason you cannot contact that office, you should contact:

▶ U S RAILROAD RETIREMENT BOARD
844 N RUSH ST
CHICAGO IL 60611-1275