UNITED STATES OF AMERICA
RAILROAD RETIREMENT BOARD

Proposed

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

APPLICATION FOR DETERMINATION OF CHILD'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-19a, Child's Disability Benefits**), which explains information you will need to answer many of the questions in this application. Please read "Important Notices" on page 14 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 Railroad Retirement Board (RRB) for Items 1 through 9 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	STREET ADDRESS →	
		b	CITY AND STATE →	
		c	ZIP CODE →	
		d	COUNTRY →	
	6	a	DAYTIME TELEPHONE NUMBER →	
		b	ALTERNATE TELEPHONE NUMBER →	
	7		APPLICANT'S SOCIAL SECURITY NUMBER →	
	8		APPLICANT'S DATE OF BIRTH →	
	9		APPLICANT'S GENDER →	❑ FEMALE ❑ MALE

Section 3 Information About Your Medical Condition

Medical Condition

10 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

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

When Condition Became Severe

12 Enter the date the condition began to ***severely*** interfere with your activities. → Month | Day | Year

How Condition Affects Work

13 Enter an "X" in the appropriate box:
Has the condition kept you from working? →
❑ Yes → **Go to Item 14**
❑ No → **Go to Item 15**

14 Describe how your condition(s) prevent you from working.

Current Work Status

15 Enter an "X" in the appropriate box:
Does this condition prevent you from working ***now?*** →
❑ Yes → **Go to Item 17**
❑ No → **Go to Item 16**

16 Enter the date this condition no longer prevented work. →

Section 4 Information About Your Medical Care

Medical Care or Examination

17 Enter an "X" in the appropriate box:
Have you received any medical care, or been examined for your condition since the date in Item 12? →
❑ Yes → **Go to Item 18**
❑ No → **Go to Section 5**

Medical Care Before 22

18 Enter information about each doctor or medical facility from whom you received treatment or care ***before age 22.***

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

Medical Care Before 22 (Continued)

18

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

Note: *If you received more medical care before age 22, use Section 9 to discuss additional treatment or care. Include the dates for each period of care.*

Other Medical Care

19 Enter information about ***any other*** doctor or medical facility from whom you have received treatment or care since the date in Item 12.

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

Other Medical Care (Continued)

19 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

Note: *If you received more medical care before age 22, use Section 9 to discuss additional treatment or care. Include the dates for each period of care.*

Activity Restriction

20 Enter an "X" in the appropriate box:
Has a medical doctor restricted your daily activities since the date in Item 12? ⟶

❑ 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 Item 18 or 19.

NAME OF MEDICAL DOCTOR

ADDRESS OF MEDICAL DOCTOR (STREET ADDRESS, CITY, STATE/PROVINCE, AND ZIP CODE)

22 Enter the date the restriction began. ⟶

Month | Year

23 List and describe the condition(s) and how your daily activites were restricted by the condition(s).

Medications

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**

Medications (Continued)	25	Enter from the prescription label the following information for all medications prescribed for you: Name or type of medication, dosage, and frequency. (For example, Penincillin, 1.5 gram tablet, 3 times a day)		
		Name/Type	Dosage (Grams, Number of Pills, Etc.)	Frequency

Section 5 Information About The Child's Daily Activities

Activities

26	Enter an "X" in the appropriate box: Do you attend a health or socialization center daily? →	❑ Yes → **Go to Item 27** ❑ No → **Go to Item 28**
27	Enter the name, address, and daytime telephone number of the center. →	NAME OF FACILITY (STREET, ADDRESS, CITY AND STATE/PROVINCE, ZIP CODE) Area Code | Telephone Number

28 Check the 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	❑	❑	❑	❑	❑ →	
Bathing	❑	❑	❑	❑	❑ →	
Sleeping	❑	❑	❑	❑	❑ →	
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)

29	a	Describe your daily activities during a normal day (i.e. a typical day from 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.)

30	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 30b** ❑ No → **Go to Item 31**
	b	Describe the volunteer work that you perform and enter the number of average 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 30d** ❑ No → **Go to Item 31**
	d	Describe the changes.	

31	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 31b** ❑ No → **Go to Section 6**
	b	Describe the social or recreational activities that you participate in and enter the number of average hours you participate per week.	
		Activity	Average Hours Per Week
	c	Enter an "X" in the appropriate box: Does your condiction(s) restrict your participation in the activities listed above? →	❑ Yes → **Go to Item 31d** ❑ No → **Go to Section 6**
	d	Describe the changes.	

Section 6 Information About Your Education And Training

Schooling and Training

32 Enter an "X" in the appropriate box:
Have you ever attended any type of school (including online) or received some type of special training? →
❑ Yes → **Go to Item 33**
❑ No → **Go to Section 7**

First School Attended

33 Enter the name and address of the first school you attended. →
SCHOOL'S NAME
STREET ADDRESS
CITY AND STATE/PROVINCE
ZIP CODE

34 Describe the type of school or training.

35 Enter the dates you attended school or training. If you are still in attendance at this school, draw a line in the "To" boxes →

From		To	
Month	Year	Month	Year

36 Enter the highest level you achieved. →

Second School Attended

37 Enter the name and address of the second school you attended. If none, enter "NONE" and (**go to Item 45**). →
SCHOOL'S NAME
STREET ADDRESS
CITY AND STATE/PROVINCE
ZIP CODE

38 Describe the type of school or training.

39 Enter the dates you attended school or training. If you are still in attendance at this school, draw a line in the "To" boxes →

From		To	
Month	Year	Month	Year

40 Enter the highest level you achieved. →

Third School Attended

41 Enter the name and address of the third school you attended. If none, enter "NONE" and (**go to Item 45**). →
SCHOOL'S NAME
STREET ADDRESS
CITY AND STATE/PROVINCE
ZIP CODE

Third School Attended (Continued)	42	Describe the type of school or training.	
	43	Enter the dates you attended school or training. If you are still in attendance at this school, draw a line in the to "To" boxes →	From: Month / Year — To: Month / Year
	44	Enter the highest level you achieved →	
		Note: *If you attended more than three schools, complete Item 45 and use Section 9 to discuss the other schools.*	
Problems in School	45	Describe any speical accommodations or assistance you received.	

Section 7 Information About Your Work Activities

Any Work	46	Enter an "X" in the appropriate box: Have you ***ever*** worked? →	❑ Yes → **Go to Item 47** ❑ No → **Go to Section 8**
Most Recent Job	47	Enter the title of your most recent job. →	
	48 a	Enter the employer's name and address. →	EMPLOYER'S NAME STREET ADDRESS CITY AND STATE/PROVINCE ZIP CODE
	48 b	Describe the type of business.	
	48 c	Is this a sheltered employment? ❑ Yes ❑ No	
	49	Enter the dates you worked at this job. If you are still working at this job, draw a line in the "To" boxes. →	From: Month / Year — To: Month / Year
	50	Enter the number of hours worked each week. →	
	51	Describe your basic duties and responsibilities for the job. Include ***any*** difficulties you had or have, perfoming the full range of duties.	
	52	Enter an "X" in the appropriate box: Did your duties differ from those of other workers with the same job title? →	❑ Yes → **Go to Item 53** ❑ No → **Go to Item 54**
	53	Describe how your duties differed from those of other workers with the same job title.	
	54	Describe the amount of supervision and assistance you received.	

Most Recent Job (Continued)

55 Explain why you stopped working at this job. If you are still working, **go to Item 56**

Second Most Recent Job

56 Enter the title of your second most recent job.
If none, enter "NONE" and **go to Item 65** →

57 a Enter the employer's name and address.

EMPLOYER'S NAME

b Describe the type of business.

STREET ADDRESS

CITY AND STATE/PROVINCE

c Is this a sheltered employment?
❑ No ❑ Yes

ZIP CODE

58 Enter the dates you worked at this job. →

From		To	
Month	Year	Month	Year

59 Enter the number of hours worked each week. →

60 Describe your basic duties and responsibilities for the job. Include **any** difficulties you had or have performing the full range of duties.

61 Enter an "X" in the appropriate box:
Did your duties differ from those of other workers with the same job title? →

❑ Yes → **Go to Item 62**
❑ No → **Go to Item 63**

62 Describe how your duties differed from those of other workers with the same job title.

63 Describe the amount of supervision and assistance you received.

64 Explain why you stopped working at this job.

Note: *If you had more than two jobs, use Section 9 to discuss the other jobs.*

Work for an Employer	65	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 66** ❑ No ⟶ **Go to Item 68**

This Calendar Year — 66

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 that month and each remaining month ***this year***.

JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE

JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER

Last Calender Year — 67

Enter your earnings, before any deduction, for each month ***last year***.

JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE

JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER

Self-employment	68	Enter an "X" in the appropriate box: Have you been self-employed in the last 12 months? ⟶	❑ Yes ⟶ **Go to Note and Item 69** ❑ No ⟶ **Go to Item 71**

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

This Calender Year — 69

Enter your earnings, before any deduction, this month and for each month you worked ***this year***.
Then starting with the current month, enter your expected earning for that month and each remaining month ***this year.***

JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE

JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER

Last Calender Year — 70

Enter your earning, before any deduction. for each month ***last year***.

JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE

JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER

	71	Enter an "X" in the appropriate box: Are you a corporate officer or owner/operator of a corporation? ⟶	❑ Yes ⟶ **Go to Note and Item 72** ❑ No ⟶ **Go to Item 72**

Note: *If answered "Yes," also complete and return to the RRB* ***Form G-252, Self-Employment/ Corporate Officer Work and Earning Monitoring.***

Work Next 12 Months	72	Enter an "X" in the appropriate box: Do you expect to work during the next 12 months? Include self-employment, if any.) ⟶	❑ Yes ⟶ **Go to Item 73** ❑ No ⟶ **Go to Section 8**

Work Next 12 Months (Continued)	73	Enter the name and address of the person or company for whom you expect to work. (If self-employed enter "Self") →	
	74	Enter the date(s) you expect to work. (For example: "June and July," "Indefinitely starting on 12-2024," etc.) →	
	75	Enter the gross amount you expect to earn. (If self-employed, enter the **net** amount.) →	

Section 8 General Information

Filing AA-3, AA-18, or AA-19	76	Enter an "X" in the appropriate box: Are you filing Form ***AA-3***, Form ***AA-18***, or Form ***AA-19*** at this time? →	❑ Yes → **Go to Item 87** ❑ No → **Go to item 77**
Guardianship	77	Enter an "X" in the appropriate box: Has the court appointed a legal guardian for you? →	❑ Yes → **Go to Item 78** ❑ No → **Go to item 80**
	78	Enter the name, address, and daytime telephone number of the court-appointed guardian. →	EMPLOYER'S NAME STREET ADDRESS CITY AND STATE/PROVINCE ZIP CODE — Area Code — Telephone Number
	79	Enter the guardian's relationship to you. →	
Child's Marital Status	80	Enter an "X" in the appropriate box: Are you now, or were you previously, married? →	❑ Yes → **Go to Item 81** ❑ No → **Go to item 85**
	81	Enter the date you were married. →	Month / Day / Year
	82	Enter an "X" in the appropriate box: Are you still married? →	❑ Yes → **Go to Item 85** ❑ No → **Go to item 83**
	83	Enter the date your marriage ended. →	Month / Day / Year
	84	Enter an "X" in the appropriate box: Was your marriage annulled? →	❑ Yes ❑ No
Social Security Benefits	85	Enter an "X" in the appropriate box: Have you filed, or do you expect to file, for monthly Social Security disability benefits or SSI? →	❑ Yes → **Go to Item 86** ❑ No → **Go to item 87**
	86	Enter the Social Security claim number and suffix under which you have filed or will file. →	Suffix
Criminal Offense	87	Enter an "X" in the appropriate box: Within the last 12 months, have you been imprisoned or given a sentence of confinement due to a conviction for criminal offense?	❑ Yes → **Go to Item 88** ❑ No → **Go to Section 9**
	88	Enter the date of the conviction. →	Month / Day / Year
	89	Enter an "X" in the appropriate box: Is your disability related to the commission of the criminal offense? →	❑ Yes ❑ No
	90	Enter the date of the sentence of confinement. →	Month / Day / Year

Criminal Offense Continued					
	91	Enter the date that confinement began. →	Month	Day	Year
	92	Enter an "X" in the appropriate box: Is your disability related to the confinement? →	❑ Yes ❑ No		
	93	Enter an "X" in the appropriate box: During the confinement are you participating in a rehabilitation program which is expected to result in the ability to engage in gainful work within a reasonable time after release? →	❑ Yes ❑ No		
	94	Enter an "X" in the appropriate box: Has the confinement ended? →	❑ Yes → **Go to Item 95** ❑ No → **Go to Section 9**		
	95	Enter the date confinement ended. →	Month	Day	Year

Section 9 Remarks

Remarks		
	96	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

97	a	Did you complete this application with the assistance of an attorney or non-family member (RRB staff excluded)? →	❑ Yes → **Go to Item 97b** ❑ No → **Go to Item 98**
	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 of this application? →	❑ Yes ❑ No
98		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 and Item 99** ❑ No → **Go to Item 99**

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

99 I Certify that the information I gave the Railroad Retiement 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 received and reviewed the booklet, **RB-19a, Child'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 an offense;
- If my address changes;
- If I marry;
- If an application is filed for social security benefits for me based on any person's earning records; or
- If my reported estimated earning amount changes;

I know that if I am receiving a disability annuity and fail to report work and earnings promptly, 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

100 If this certification is signed by mark (X) in Item 99, 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 15 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 15, 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

- **Work–**If you perform work for any employer, railroad or nonrailroad, or performs any self-employment work.
- **Earning–**If you reported estimated earnings and the amount changes.
- **Improvement in your Condition–**If your condition improves and a doctor advises you are able to work.
- **Marriage–**If you marry.
- **Social Security–**If an application is filed for social security benefits for you based on **any** person's earnings record.
- **Address–**If your address changes.
- **Crimianl Offense–**If you are confined in a jail, prison, penal institution, or correctional facility due to a conviction for a criminal offense.

How To Report Changes

When a change occurs after you become entitled to disability benefits, it should be reported 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