

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
1 2	1 3	2 0 2 4

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 <input type="checkbox"/> Yes <input type="checkbox"/> No									
		Additional Condition(s)	Medical Attached <input type="checkbox"/> Yes <input type="checkbox"/> 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? _____ →	<input type="checkbox"/> Yes → Go to Item 10 <input type="checkbox"/> No → Go to Item 12									
	10	Enter an "X" in the appropriate box: Has your condition caused you to change: Your job duties? _____ → Your hours of work? _____ → Your attendance? _____ → Anything else about your work? _____ →	<table border="0"> <tr> <td>Yes</td> <td>No</td> </tr> <tr> <td><input type="checkbox"/> If "Yes" to any item, go to Item 11</td> <td><input type="checkbox"/> If "No" to all items, go to Item 12</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>				Yes	No	<input type="checkbox"/> If "Yes" to any item, go to Item 11	<input type="checkbox"/> If "No" to all items, go to Item 12	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No										
<input type="checkbox"/> If "Yes" to any item, go to Item 11	<input type="checkbox"/> If "No" to all items, go to Item 12											
<input type="checkbox"/>	<input type="checkbox"/>											
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? _____ →	<input type="checkbox"/> Yes → Go to Item 14b <input type="checkbox"/> 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. _____ →	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		b	Enter an "X" in the appropriate box: Are you scheduled for any additional medical care for your condition(s) (i.e. surgeries, etc.) after you file this application? ▶	<input type="checkbox"/> Yes Explain below <input type="checkbox"/> 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? →		<input type="checkbox"/> Yes → Go to Item 17	
				<input type="checkbox"/> 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 <input type="checkbox"/> Outpatient <input type="checkbox"/>				
	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 <input type="checkbox"/> Outpatient <input type="checkbox"/>			
		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 <input type="checkbox"/> Outpatient <input type="checkbox"/>			
		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? →		<input type="checkbox"/> Yes → Go to Item 19	
				<input type="checkbox"/> 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? →		<input type="checkbox"/> Yes → Go to Item 21	<input type="checkbox"/> 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). _____ →	<input type="checkbox"/> Yes → Go to Item 25 <input type="checkbox"/> No → Go to Section 5	
	25	Enter from the prescription labels the following information 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)? _____ →	<input type="checkbox"/> Yes → Go to Item 27b <input type="checkbox"/> 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.	<input type="checkbox"/> Technical <input type="checkbox"/> Specialized <input type="checkbox"/> Vocational <input type="checkbox"/> Services: _____ <input type="checkbox"/> 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? _____ →	<input type="checkbox"/> Yes → Go to Item 29b <input type="checkbox"/> No → Go to Item 30	
		b	Describe the type of technical school you attended, 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? _____ →	<input type="checkbox"/> Yes → Go to Item 31 <input type="checkbox"/> No → Go to Section 6		
	31	Enter an "X" in the appropriate box: Is the degree, certificate, or license you received currently valid? _____ →	<input type="checkbox"/> Yes → Go to Item 32 <input type="checkbox"/> No → Go to Section 6		
32	Enter an "X" in the appropriate box: Have you used any of the training in your work? _____ →	<input type="checkbox"/> Yes → Go to Item 33 <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> →	
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> →	
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> →	
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> →	
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> →	
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> →	
Dressing (Tying Shoes, Combing Hair, Etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> →	
Other Bodily Needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> →	
Indoor Chores (Meal Preparation, Laundry, Cleaning, Etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> →	
Outdoor Chores (Shopping, Yardwork, Etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> →	
Driving a Motor Vehicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> →	
Using Public Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> →	
Conducting Personal Business (Talking to and Dealing with Other People)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> →	
Reading English (For example, newspapers and magazines)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> →	
Writing English (For example, notes and letters)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> →	

Daily Activities (Continued)	34	a	Describe your daily activities during a normal day (i.e., typical day from the time you get up until you go to bed.)		
		b	Describe and explain if your condition affects your 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)	<input type="checkbox"/> Yes → Go to Item 35b	<input type="checkbox"/> 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? _____ →	<input type="checkbox"/> Yes → Go to Item 35b	<input type="checkbox"/> 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. _____ →	<input type="checkbox"/> Yes → Go to Item 36b	<input type="checkbox"/> No → Go to Section 7
		b	Describe the social or recreational activities that you participate in, and enter the average 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? _____ →	<input type="checkbox"/> Yes → Go to Item 36d	<input type="checkbox"/> No → Go to Section 7	
		d	Describe the changes.		

Section 7 Information about your Work and Earnings

Work Activities	37	Enter an "X" in the appropriate box: Have you ever been employed or self-employed? _____ →	<input type="checkbox"/> Yes → Go to Note and Item 38 <input type="checkbox"/> 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.) _____ →	<input type="checkbox"/> Yes → Go to Item 39 <input type="checkbox"/> 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.																										
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 16.6%;">JANUARY</td> <td style="width: 16.6%;">FEBRUARY</td> <td style="width: 16.6%;">MARCH</td> <td style="width: 16.6%;">APRIL</td> <td style="width: 16.6%;">MAY</td> <td style="width: 16.6%;">JUNE</td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>JULY</td> <td>AUGUST</td> <td>SEPTEMBER</td> <td>OCTOBER</td> <td>NOVEMBER</td> <td>DECEMBER</td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>					JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE							JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER						
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JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER																							
Last Calendar Year	40	Enter your earnings, before any deductions, for each month last year .																										
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Self-Employment	41	Enter an "X" in the appropriate box: Have you been self-employed in the last 12 months? _____ →	<input type="checkbox"/> Yes → Go to Note and Item 42 <input type="checkbox"/> 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 .																										
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Last Calendar Year	43	Enter your net earnings, before any deductions, for each month last year .																										
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Work Next 12 Months	44	Enter an "X" in the appropriate box: Do you expect to work during the next 12 months? (Include self-employment, if any.) _____ →	<input type="checkbox"/> Yes → Go to Item 45 <input type="checkbox"/> 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? _____ →	<input type="checkbox"/> Yes → Go to Item 54 <input type="checkbox"/> 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? _____ →	<input type="checkbox"/> Yes → Go to Item 50 <input type="checkbox"/> No → Go to Item 51									
	50	Enter the Social Security claim number under which you have filed or will file.	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>									
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. _____ →	<input type="checkbox"/> Yes → Go to Item 52 <input type="checkbox"/> No → Go to Item 54									
	52	Are you or were you an employee of the Federal Government?.	<input type="checkbox"/> Yes → Go to Note and Item 54 <input type="checkbox"/> No → Go to Item 53									
	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 being deducted from my public service earnings? Note: If you answer "Yes," also complete and return the RRB Form G-208, Public Service Pension Questionnaire, and verification of your pension.	<input type="checkbox"/> Yes → Go to Item 54 <input type="checkbox"/> No → Go to Note and Item 54 Note: If you answer "No," also complete and return the RRB Form G-208, Public Service Pension Questionnaire, 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? _____ →	<input type="checkbox"/> Yes → Go to Item 55 <input type="checkbox"/> No → Go to Section 9									
	55	Enter the date of the conviction. _____ →	<table border="1"> <tr> <th>Month</th> <th>Day</th> <th>Year</th> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table>	Month	Day	Year						
	Month	Day	Year									
56	Is your disability related to the commission of the criminal offense? _____ →	<input type="checkbox"/> Yes <input type="checkbox"/> 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? _____ →	<input type="checkbox"/> Yes <input type="checkbox"/> No			
60	Enter an "X" in the appropriate box: Has the confinement ended? _____ →	<input type="checkbox"/> Yes → Go to Item 61 <input type="checkbox"/> 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)? →	<input type="checkbox"/> Yes → Go to Item 63b <input type="checkbox"/> 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 application? →	<input type="checkbox"/> Yes <input type="checkbox"/> No

64	Enter an "X" in the appropriate box: Will you have a guardian or other representative sign this application on your behalf? →	<input type="checkbox"/> Yes → Go to Note <input type="checkbox"/> No → Go to Item 65
----	--	--

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 for Substitution of Payee.**

65	<p>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 received 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.</p> <p>I agree to immediately notify the RRB:</p> <ul style="list-style-type: none"> • 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 security 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 <p>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.</p> <p>Signature → </p> <p>(First Name, Middle Initial, Last Name)</p> <p>Date →</p> <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 30px;">Month</td> <td style="width: 30px;">Day</td> <td style="width: 30px;">Year</td> </tr> <tr> <td style="text-align: center;"> </td> <td style="text-align: center;"> </td> <td style="text-align: center;"> </td> </tr> </table>	Month	Day	Year			
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 an 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