

APPLICATION FOR DETERMINATION OF CHILD'S DISABILITY

DO NOT WRITE IN THIS SPACE

OFFICIALLY FILED			OFFICE NUMBER		
MONTH	DAY	YEAR			
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
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 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 →	<input type="checkbox"/> FEMALE <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No		
		Additional Condition(s)	Medical Attached <input type="checkbox"/> Yes <input type="checkbox"/> 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? _____ →	<input type="checkbox"/> Yes → Go to Item 14 <input type="checkbox"/> 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 ? _____ →	<input type="checkbox"/> Yes → Go to Item 17 <input type="checkbox"/> 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? _____ →	<input type="checkbox"/> Yes → Go to Item 18 <input type="checkbox"/> 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 <input type="checkbox"/> OUTPATIENT <input type="checkbox"/>			
			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 <input type="checkbox"/> OUTPATIENT <input type="checkbox"/>						
PATIENT NUMBER	Area Code	Telephone Number				
DATES TREATED OR TESTED			DESCRIBE TYPE OF TREATMENT OR TESTING			
Other Medical Care	19	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			
<p>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.</p>						

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 <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			
<div style="border: 1px solid black; border-radius: 15px; padding: 5px; display: inline-block;"> <p>Note: <i>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.</i></p> </div>						
Activity Restriction	20	Enter an "X" in the appropriate box: Has a medical doctor restricted your daily activities since the date in Item 12? _____ →			<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 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 activities were restricted by the condition(s).					
Medications	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	

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, Penicillin, 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? →		<input type="checkbox"/> Yes → Go to Item 27	<input type="checkbox"/> 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	<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"/> →	
Bathing	<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"/> →	
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)	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.)	<input type="checkbox"/> Yes → Go to Item 30b <input type="checkbox"/> 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?	<input type="checkbox"/> Yes → Go to Item 30d <input type="checkbox"/> 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.	<input type="checkbox"/> Yes → Go to Item 31b <input type="checkbox"/> 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 condition(s) restrict your participation in the activities listed above?	<input type="checkbox"/> Yes → Go to Item 31d <input type="checkbox"/> 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 \longrightarrow online) or received some type of special training?	<input type="checkbox"/> Yes \longrightarrow Go to Item 33 <input type="checkbox"/> No \longrightarrow Go to Section 7												
First School Attended	33	Enter the name and address of the first school you attended. \longrightarrow	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 \longrightarrow	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2" style="text-align: center;">From</th> <th colspan="2" style="text-align: center;">To</th> </tr> <tr> <th style="text-align: center;">Month</th> <th style="text-align: center;">Year</th> <th style="text-align: center;">Month</th> <th style="text-align: center;">Year</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"> </td> <td style="text-align: center;"> </td> <td style="text-align: center;"> </td> <td style="text-align: center;"> </td> </tr> </tbody> </table>	From		To		Month	Year	Month	Year				
	From		To												
Month	Year	Month	Year												
36	Enter the highest level you achieved. \longrightarrow														
Second School Attended	37	Enter the name and address of the second school you attended. If none, enter "NONE" and (go to Item 45). \longrightarrow	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 \longrightarrow	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2" style="text-align: center;">From</th> <th colspan="2" style="text-align: center;">To</th> </tr> <tr> <th style="text-align: center;">Month</th> <th style="text-align: center;">Year</th> <th style="text-align: center;">Month</th> <th style="text-align: center;">Year</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"> </td> <td style="text-align: center;"> </td> <td style="text-align: center;"> </td> <td style="text-align: center;"> </td> </tr> </tbody> </table>	From		To		Month	Year	Month	Year				
	From		To												
Month	Year	Month	Year												
40	Enter the highest level you achieved. \longrightarrow														
Third School Attended	41	Enter the name and address of the third school you attended. If none, enter "NONE" and (go to Item 45). \longrightarrow	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	To		
			Month	Year	Month	Year
	44	Enter the highest level you achieved				
<p>Note: If you attended more than three schools, complete Item 45 and use Section 9 to discuss the other schools.</p>						

Problems in School	45	Describe any special accommodations or assistance you received.
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Section 7 Information About Your Work Activities

Any Work	46	Enter an "X" in the appropriate box: Have you ever worked?	<input type="checkbox"/> Yes → Go to Item 47 <input type="checkbox"/> No → Go to Section 8
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Most Recent Job	47	Enter the title of your most recent job.		
	48	a	Enter the employer's name and address.	EMPLOYER'S NAME
		b	Describe the type of business.	STREET ADDRESS
	c	Is this a sheltered employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	CITY AND STATE/PROVINCE	ZIP CODE

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	To		
		Month	Year	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, performing the full range of duties.
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52	Enter an "X" in the appropriate box: Did your duties differ from those of other workers with the same job title?	<input type="checkbox"/> Yes → Go to Item 53 <input type="checkbox"/> No → Go to Item 54
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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			
		c	Is this a sheltered employment? <input type="checkbox"/> No <input type="checkbox"/> Yes	CITY AND STATE/PROVINCE			
	58	Enter the dates you worked at this job. →		From Month	Year	To 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? →		<input type="checkbox"/> Yes → Go to Item 62 <input type="checkbox"/> 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".) →	<input type="checkbox"/> Yes → Go to Item 66 <input type="checkbox"/> 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 .																									
<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	67	Enter your earnings, before any deduction, for each month last year .																									
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Self-employment	68	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 69 <input type="checkbox"/> No → Go to Item 71																								
<div style="border: 1px solid black; border-radius: 15px; padding: 10px; width: fit-content; margin: 0 auto;"> <p>Note: If answered "Yes," also complete and return to the RRB Form AA-4, Self Employment Questionnaire.</p> </div>																											
This Calendar 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 .																									
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Last Calendar Year	70	Enter your earning, before any deduction. for each month last year .																									
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	71	Enter an "X" in the appropriate box: Are you a corporate officer or owner/operator of a corporation? →	<input type="checkbox"/> Yes → Go to Note and Item 72 <input type="checkbox"/> No → Go to Item 72																								
<div style="border: 1px solid black; border-radius: 15px; padding: 10px; width: fit-content; margin: 0 auto;"> <p>Note: If answered "Yes," also complete and return to the RRB Form G-252, Self-Employment/Corporate Officer Work and Earning Monitoring.</p> </div>																											
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.) →	<input type="checkbox"/> Yes → Go to Item 73 <input type="checkbox"/> 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? _____ →	<input type="checkbox"/> Yes → Go to Item 87 <input type="checkbox"/> No → Go to item 77	
	Guardianship	77	Enter an "X" in the appropriate box: Has the court appointed a legal guardian for you? _____ →	<input type="checkbox"/> Yes → Go to Item 78 <input type="checkbox"/> No → Go to item 80
78		Enter the name, address, and daytime telephone number of the court-appointed guardian. _____ →	EMPLOYER'S NAME	
79		Enter the guardian's relationship to you. _____ →	STREET ADDRESS	
			CITY AND STATE/PROVINCE	
			ZIP CODE	Area Code Telephone Number
Child's Marital Status	80	Enter an "X" in the appropriate box: Are you now, or were you previously, married? _____ →	<input type="checkbox"/> Yes → Go to Item 81 <input type="checkbox"/> No → Go to item 85	
	81	Enter the date you were married. _____ →	Month	Day
	82	Enter an "X" in the appropriate box: Are you still married? _____ →	<input type="checkbox"/> Yes → Go to Item 85 <input type="checkbox"/> No → Go to item 83	
	83	Enter the date your marriage ended. _____ →	Month	Day
	84	Enter an "X" in the appropriate box: Was your marriage annulled? _____ →	<input type="checkbox"/> Yes <input type="checkbox"/> 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? _____ →	<input type="checkbox"/> Yes → Go to Item 86 <input type="checkbox"/> 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? _____ →	<input type="checkbox"/> Yes → Go to Item 88 <input type="checkbox"/> No → Go to Section 9	
	88	Enter the date of the conviction. _____ →	Month	Day
	89	Enter an "X" in the appropriate box: Is your disability related to the commission of the criminal offense? _____ →	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	90	Enter the date of the sentence of confinement. _____ →	Month	Day

Section 10 Certification

97	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 97b <input type="checkbox"/> 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? →	<input type="checkbox"/> Yes <input type="checkbox"/> No

98		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 and Item 99 <input type="checkbox"/> No → Go to Item 99
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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	<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-19a, Child'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 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; <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;"> <thead> <tr> <th>Month</th> <th>Day</th> <th>Year</th> </tr> </thead> <tbody> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 40px; height: 20px;"></td> </tr> </tbody> </table>			Month	Day	Year			
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 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

- **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.
- **Criminal 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