United States of America
Railroad Retirement Board

CURRENT

Form Approved
OMB No. 3220-0039

Statement of Sickness

Instructions: ***This form is to be executed by a health care provider for the purpose of this form a health care provider is (1) a doctor trained in medical, surgical, dental or psychological diagnosis of the infirmity described, (2) a certified nurse/ midwife in cases of pregnancy or childbirth, (3) a supervisory official of a hospital or similar institution, (4) a chiropractor, (5) a Physician Assistant - Certified, or (6) a nurse practitioner. This form should be completed and returned to the patient immediately for prompt mailing; otherwise he/she may lose benefits. Supplementary medical information may be attached or furnished directly to the Railroad Retirement Board (RRB) at the address shown below. If such information is furnished, please include the patient's social security number and name on the report. Please complete section 2 on the reverse side if patient is incapable of signing forms.***

The RRB is not liable for any charge in connection with completing this form.

1. Patient's Name (First, Middle, and Last)

2. Patient's Social Security Number

3. Have you examined or treated the patient for his or her injury or illness? ❑ Yes ❑ No – **Go to Item 9**

a. Date patient became sick or injured

b. List all dates of examination and treatment for this infirmity

c. Probable date of next examination

4. Diagnosis and concurrent conditions

5. Does the patient's condition require surgery? ❑ Yes ❑ No – **Go to Item 6**

a. Date on which surgery was or will be performed

b. Surgical procedure that was or will be performed

6. Does the patient's condition require hospitalization?

❑ Yes – Enter the period of hospital confinement: From _____ To _____

❑ No

7. If patient is not working because of maternity or childbirth, complete 7a and 7b.

a. Date patient became unable to work ▶

b. Estimated or actual date of delivery ▶

8. Give the date you believe the patient became or will become able to resume work in his or her occupation. (If indefinite or unknown, please give an estimated date.) ▶

9. I certify that the information I am giving is true, complete, and correct. I understand that criminal and civil penalties may be imposed on me for false or fraudulent statements or for withholding information to cause or prevent payment of benefits by the RRB.

Please print or type:

Name of Health Care Provider	Signature of Health Care Provider	Degree/Title
Address	Office Telephone Number (Include Area Code) ( )	Date
	National Provider Identifier	

PAPERWORK REDUCTION ACT NOTICE TO HEALTH CARE PROVIDER

Medical evidence is needed to support the payment of claims for sickness benefits under the Railroad Unemployment Insurance Act (RUIA). The RRB is authorized to collect this information under section 12(i) of the RUIA. You are not required to furnish this information. If you do not, however, no benefits can be paid to your patient. We estimate this form and the form on the back of this page take an average of 8 and 6 minutes to complete, respectively. The estimates include the time for reviewing the instructions, getting the needed data, and reviewing the completed forms. Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number. If you wish, send comments regarding the accuracy of our estimate or any other aspect of this form, including suggestions for reducing completion time, to the Railroad Retirement Board, ATTN: Bureau of Information Services/Policy & Compliance, 844 N. Rush St., Chicago, IL 60611-1275. Send completed forms to:

U.S. RAILROAD RETIREMENT BOARD
OFFICE OF PROGRAMS—OPERATIONS
POST OFFICE BOX 10695
CHICAGO, ILLINOIS 60610-0695

Health Care Provider: See Next Page

Form approved
OMB No. 3220-0034

Statement Of Authority To Act For Employee

It is not necessary to complete this form for an employee who can sign papers or can sign by mark and understands transactions relating to his or her sickness benefits.

Instructions

1. Complete Section 1 and have the employee's medical doctor complete Section 2. If you are not related to the employee by blood or marriage, state your relationship and explain why no relative is acting for the employee. For example, an employee's union representative might explain: "I am his union chairman. He has no immediate family."

2. Complete this statement by following the instructions in the UB-11 booklet under "Instructions for Completing Forms, Statement of Authority to Act for Employee (SI-10)." Signing this statement gives you the authority to sign any claim forms on behalf of the employee. When signing claim forms use your full name, and beneath your signature, write "On behalf of" and the employee's full name.

3. Return this form with the next application or claim form you file with the RRB.

Section 1 Statement of Individual Acting for Employee

It is my belief that _____ _____
(Employee's Name) (Social Security Number)

whose address is _____
(Employee's Address)

is at this time incapable of signing forms in connection with obtaining sickness benefits under the Railroad Unemployment Insurance Act; of transacting the necessary business relative to his or her application and claims for such benefits; and of applying the proceeds of any sickness benefit payments.

I believe the employee to be incapable because _____

_____
(Briefly describe employee's condition)

My relationship to the employee is _____

I affirm that, in the transaction of business relating to the application and claims of this employee, including the use of any benefit payments, I will act on behalf of and in the best interest of the employee. I will promptly notify the RRB at such time as this employee's condition changes so that I need no longer act for him or her. I understand that criminal and civil penalties may be imposed on me for providing false, incomplete, or fraudulent statements; using the benefits received on something other than the claimant; or for withholding information to cause the payment of benefits. I certify that, to the best of my knowledge, the information I have provided is true, complete, and correct.

Name (please print)	Signature			Phone Number ( )
Street Address (please print)	City	State	ZIP Code	Date

Section 2 Statement of Employee's Health Care Provider

I have examined the employee named above and find that he/she is incapable of signing forms and transacting business relative to his/her claims for sickness benefits under the Railroad Unemployment Insurance Act.

Name of Health Care Provider (please print)		Signature of Health Care Provider		
Office Street Address (please print)	City	State	ZIP Code	Date
National Provider Identifier				