United States of America
Railroad Retirement Board

Form Approved
OMB No. 3220-0039

Application for Sickness Benefits

Section A Identifying Information

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

2. Social Security Number

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3. Employee's Street Address, City, State and ZIP Code (Including Apartment Number)

4. Date of Birth

Month		Day		Year	

5. Sex
- ☐ Male
- ☐ Female

6. Telephone Number (Include Area Code)
( )

Section B Infirmity and Employment Information

7. Date You Became Sick or Injured _____

8. Date You Last Worked for a Railroad _____

9. Last Railroad Employer (Name of Company) _____

10. Location of Last Railroad Employment (City/State) _____

11. Last Railroad Occupation _____

12. Department _____

13. If you worked for a nonrailroad employer after the date shown in Item 8, complete Items A, B, and C, below. Otherwise, **go to Item 14.**

A. Last Nonrailroad Employer (Name of Company) _____

B. Last Occupation After Railroad Work _____

C. Date Last Worked After Railroad Work _____

Section C Accident and Insurance Information

14. Are you applying for sickness benefits because you were injured at work or have a work-related illness? ☐ Yes ☐ No

15. Have you filed or do you expect to file a lawsuit or claim against any person or company for personal injury?

☐ Yes - **Complete Items A-D, below** ☐ No - **Go to Item 16**

A. Furnish the name and complete address of the person or company.

Name _____

Address _____

City, State, ZIP Code _____

B. Give the place where the injury occurred. _____

C. Were you injured in an automobile accident? ☐ Yes ☐ No - **Go to Item 16**

D. If you were injured in an automobile accident, provide information about all the vehicles, ***other than your own,*** that were involved in the accident that caused your injury. Information about your vehicle and insurance company is not needed. If you need more space attach a separate sheet of paper.

Owner of Car (other vehicle)	**Driver (other vehicle)**
Name	Name
Address	Address
City, State, ZIP Code	City, State, ZIP Code
Insurance Company (other vehicle)	**Policy Information (other vehicle)**
Name	Policy Number
Address	Claim Number
City, State, ZIP Code	

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Section D Claim for Sickness Benefits Information

16. Enter the earliest date you wish to claim sickness benefits. _____

17. Are you claiming all the days of sickness beginning with the date you entered in Item 16? (**Note:** You may claim rest days if you were unable to work and did not receive pay from your employer.) ❑ Yes - **Go to Item 19** ❑ No - **Go to Item 18**

18. Enter any dates that you do not wish to claim. _____

19. Enter the date you returned to work (if applicable). _____

20. **You must complete all boxes** to indicate if you have received or will receive any of the following payments for your days of sickness. If you check "YES" for any item, be sure to provide the requested information.

A. WAGES (Include Railroad and Nonrailroad Wages)

YES	NO	If "YES," show the dates for which you were paid in Month/Day/Year format below.
❑	❑	Regular Wages. . . . . _____
❑	❑	Vacation Pay . . . . . _____
❑	❑	Holiday Pay . . . . . _____
❑	❑	Military Reservist Pay . . . . . _____
❑	❑	Wage Continuation Pay . . . . . _____
❑	❑	Earnings from Self-Employment . . _____
❑	❑	Sick Pay from Your Employer . . . . _____

(but not payments supplementing Railroad Retirement Board (RRB) benefits. See Booklet UB-11)

B. GOVERNMENTAL PAYMENTS (Not RRB Sickness Benefits)

YES	NO	If "YES," enclose copy of award letter and complete Items 1 - 3 below.
❑	❑	Sickness or Unemployment Benefits Under Any Other Law
❑	❑	Social Security Benefits
❑	❑	Railroad Retirement or Disability Annuity
❑	❑	Military Retirement Pay
❑	❑	Worker's Compensation
❑	❑	Retirement Payments Under Another Law

1. Beginning Date of Payment _____
2. Gross Amount of Payment $ _____
3. How often do you receive the payment?
   ❑ Weekly ❑ Monthly ❑ Yearly
   ❑ Other: _____

C. OTHER PAYMENTS

YES	NO	If "YES," complete Items 1 and 2.
❑	❑	Settlement, Judgment or Damages for Personal Injury
❑	❑	Advances
❑	❑	Separation Allowance (Buyout, Severance Pay)

1. Date of Payment _____
2. Paid By: _____

21. If the date you are submitting this form is **more than 30 days** after the date you entered in Item 16, answer the following:
A. Why did it take more than 30 days to submit this form? If more space is needed, attach a separate sheet of paper.

_____

B. How did you obtain this form? _____

C. Who provided this form to you? _____

D. On what date did you obtain the form? _____

E. Furnish the name and title of any person from whom you asked for help in completing and filing the forms.

NAME_____ TITLE _____

Section E Direct Deposit Information

22. Benefits are normally paid by Direct Deposit to your bank, savings and loan, credit union, or other financial institution. To provide the information we need to correctly deposit your payments, **attach a voided personal check and go to Item 23**, or call your financial institution for the information you need to complete Items A-E.

A. Routing Transit Number | | | | | | | | | | B. Account No. _____

C. Account Type:
❑ Checking ❑ Saving

D. Name of Financial Institution: _____

E. Telephone No. (Include Area Code) (_____)_____

Section F Certification and Signature

23. I waive any "doctor-patient privilege" I may have with respect to the disclosure of information concerning the period of sickness or injury on which my claim is based. I certify that I understand and agree to the requirements in Booklet UB-11. I know that disqualification and civil and criminal penalties may be imposed on me for false or fraudulent statements or claims or for withholding information to get benefits from the RRB. I affirm that the information given on this form is true, correct and complete. **NOTE:** If the sick or injured employee is unable to sign this form, sign your name and complete Section 1 of the attached Form SI-10, Statement of Authority to Act for Employee.

SIGNATURE _____ **DATE** _____

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Statement of Sickness

Instructions: ***This form is to be executed by (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 Doctor	Signature of Doctor	Degree/Title
Address	Office Telephone Number (Include Area Code) ( )	Date
	National Provider Identifier	

PAPERWORK REDUCTION ACT NOTICE TO DOCTOR

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 Chief of Information Resources Management, Railroad Retirement Board, 844 N Rush Street, Chicago, Illinois, 60611-2092. Send completed forms to:

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

Doctor: See Next Page

United States of America
Railroad Retirement Board

Form Approved
OMB No. 3220-0034

Statement of Authority to Act for Employee

Employee _____

Social Security Number _____

This statement is to be completed when applying for sickness benefits under the Railroad Unemployment Insurance Act (RUIA) on behalf of an employee who is incapable of signing documents and transacting business in connection with his or her benefit payments. The Railroad Retirement Board's (RRB) authority for obtaining this information is section 5(b) of the RUIA. **It is not necessary to file this statement for an employee who can sign papers by mark and understand the transactions.** In such a case, the application should be filled out for the employee, signed by the employee by mark, and the mark witnessed by two persons who should give their full addresses.

Although you are not required to provide information requested on this form, if you fail to do so, the RRB cannot grant authorization to you to act on behalf of the employee.

We estimate this form takes an average of 6 minutes to complete (4 minutes for the applicant and 2 minutes for the doctor), including the time for reviewing the instructions, obtaining 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 completion time, to: Associate Chief Information Officer for Policy and Compliance, Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois 60611-1275.

Please read the instructions on the *next page* concerning the completion and return of this form to the Railroad Retirement Board.

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 Doctor

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