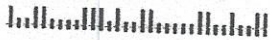




UNITED STATES OF AMERICA
RAILROAD RETIREMENT BOARD
JUDGE JAMESON FED BLDG, RM 101
2900 FOURTH AVE NORTH
BILLINGS, MT 59101-1266
E-MAIL: billings@rrb.gov

OFFICE HOURS: M-F 9:00 AM TO 3:30 PM
CLOSED FEDERAL HOLIDAYS

TOLL-FREE NUMBER: 1-877-772-5772
FACSIMILE NUMBER: 1-406-247-7379



In reply refer to

Dear

Disability Application Instruction Letter

The Railroad Retirement Act limits retroactivity of a disability annuity to no more than 12 months (6 months for Disabled Child's annuity) before the application filing date. We can use the date you first contacted us, as your application filing date, as long as an application is actually filed by Otherwise, we will consider your filing date as the date that the completed application is received by us. Our representatives are available to answer questions or assist you in processing your claim. For better service, it is recommended that you call for an appointment since substantial time is needed to complete a disability application. If you have questions or problems completing these forms, please do not hesitate to contact the office shown above.

The checked boxes indicate the forms you need to support your claim for disability under the Railroad Retirement Act.

Medical Records:

- Form G-250**, Medical Assessment, is accompanied by Form RL-250, Request for Medical Assessment Letter, and should be given to your doctor(s) to assess how your impairment(s) affects your ability to perform certain work-related activities. Form G-250 should be documented by objective medical evidence from your medical records. Be sure you authorize your doctor(s) to release your records to us. Ask that copies of the records pertaining to your impairment(s) are included.
- Form G-260**, Report of Seizure Disorder, is to be given to your doctor(s) if you have been treated for a seizure disorder. Be sure that you give us information about any anti-convulsant medication you are taking. You may also be asked to submit a statement, describing your seizure, from someone other than yourself who has witnessed your seizure.
- Form G-197**, Authorization to Release Information to the Railroad Retirement Board, is to be signed to authorize the release of medical records to us. It is to be returned to the address above.

Unless otherwise specified, we will not need medical records prior to the date you believe your condition began to adversely affect your work. If you have not been seen by a doctor in the past

18 months, be sure to let us know since we may need to set up a specialized examination. While any specialized examination which we order will be conducted at our expense, you will be responsible for transportation and any other costs you incur going to the appointment.

If you are filing as a disabled child, you will have to furnish evidence to establish disability for all work prior to age 22.

If you are filing as a widow(er), you will have to establish disability within a prescribed period. Generally, this is 7 years from the later of the railroad employee's death or your last entitlement to a widow(er)'s annuity based on prior disability or having a child in your care.

Work/Tax Information:

- Form RRB-W4P**, Withholding Certificate for Railroad Retirement Payments. Part of your railroad retirement benefits may be subject to Federal income tax withholding. Use this form to indicate whether you want taxes withheld from your payments and how much to withhold.
- Form G-251**, Vocational Report. Show all railroad and nonrailroad jobs you have performed in the last 15 years before you stopped working. (If you have a 6th grade education or less and performed only heavy unskilled labor for 35 years or more, list all of the jobs you have had since you began work.) Be sure to **fully describe** what you did on a typical day, what tools you used, what skills were required, and to what extent you supervised or were supervised by others.
- Form AA-4**, Self-Employment and Substantial Service Questionnaire. This form is necessary if you are self-employed or you were self-employed within the last fifteen years. You may be required to furnish supporting documents such as tax records.

Applications:

- Form AA-1**, Application for Employee Annuity.
- Form AA-1d**, Application for Determination of Employee's Disability.
- Form AA-17**, Application for Widow(er)'s Annuity; **AA-17b**, Application for Determination of Widow(er)'s Disability.
- Form AA-19**, Application for Child's Annuity; **AA-19a**, Application for Determination of Child's Disability.
- Form AA-5**, Application for Substitution of Payee. Fill out this application if you are filing a claim for disability on behalf of a Railroad Retirement Board claimant.


Please answer all questions as required by the appropriate applications and double check your information before signing the form.

Proof Documents Required:

- Birth Certificate
- Marriage Certificate
- Social Security Card
- Military Service Discharge Record
- Death Certificate

You must provide the original proof documents or a certified copy of the original proof documents when filing your application. The documents will be returned.

Sincerely,


Becky Jo Harris

INSTRUCTIONS FOR FILING A RAILROAD RETIREMENT DISABILITY APPLICATION

Please follow these steps in filing your disability annuity:

1. Complete the enclosed forms in as much detail as possible. It is important that you provide the Board with complete and detailed information to determine your disability.
2. Obtain **ALL MEDICAL RECORDS** from your physician(s) and/or hospital(s) from the last 18 months. A medical release form and cover letters for your providers have been enclosed.
3. If you are not in the Billings area, return the completed forms, along with your medical records, to this office. Your representative will contact you for an appointment to complete the processing of your disability.
4. If you are in the Billings area, contact the office when you have completed the forms and obtained your medical records. Your representative will make an appointment for you to complete the processing of your disability.

NOTE: Because this final disability processing usually takes at least an hour, an appointment is necessary to ensure adequate time is scheduled for this application.

If you have any questions or concerns about your application, don't hesitate to contact us during office hours.



NOTICE

It is **highly** recommended that you provide the **Railroad Retirement Board (RRB)** with the appropriate **"proofs"** as soon as you become vested! These **"proofs"** are:

- 1) **your birth certificate**
- 2) **birth certificate for your spouse**
- 3) **marriage certificate**
- 4) **spouse social security number**
- 5) **proof of military service, if any (DD-214)**

It is also recommended you provide copies of any final divorce decrees. Remember to include **your social security number** with all correspondence so we know where it all belongs! We need originals but **we will return all original documents!** This documentation is needed **before** we can file any applications so get it in now and beat the rush!! Send all information to:

**U. S. Railroad Retirement Board
2900 Fourth Avenue North, Room 101
Billings, MT 59101-1266**

TYPES OF PROOFS

PROOF OF AGE – The best proof is a certified copy of the civil or church record of the date of your birth made at or near the time of birth. Such proof should be submitted unless it can be shown that these records do not exist. In the latter case, you should submit the next oldest record you can locate, such as an insurance policy, fraternal record, or other document that shows (a) your name and your date of birth or age and (b) the date the record was made, which must be more than five years before the date on which you file an application for an annuity.

PROOF OF MARRIAGE – The best way to prove a marriage is by furnishing a certified copy of the public marriage record, a certified copy of the church marriage record or the original marriage certificate. If none of these proofs is obtainable, give the reason and submit a statement from the clergyman or official who performed the marriage ceremony. When proving a marriage to other than the railroad retirement employee, provide the full name of the spouse, date and place of the marriage, when the marriage ended, and the former spouse's social security number.

PROOF OF DIVORCE – Such proof may be the original divorce decree, a certified copy of the divorce decree or an abstract certification of the divorce decree.

PROOF OF RELATIONSHIP – The preferred proof of relationship is a certified copy of a civil or church record of such person's birth. If neither of these proofs is obtainable, give the reason and submit another record such as a hospital birth record or certificate, a Bible or family record, a school record or the affidavits of two disinterested individuals who have knowledge of the relationship. Any evidence which is submitted to show the relationship of a brother or sister must show the claimant's name, the name of the his parents, and must reflect the parent and child relationship. If the evidence submitted as proof of marriage or relationship also indicates the age or date of birth of the individual to whom the evidence pertains, separate proof of age is not required.

PROOF OF MILITARY SERVICE – Acceptable proof may be the original certificate of discharge, or any official military record that shows the dates of your active service, or a certified copy of the original document.

PROOF OF DEATH – Acceptable proofs of death include a certified copy of the death certificate, which may be obtained from the city, county, or State Department of Health or Registrar of Vital Statistics in the state where death occurred; or a statement of death completed by the funeral director on RRB Form G-273a, Funeral Director's Statement of Burial Charges.

PROOF OF PAYMENT OF BURIAL EXPENSES – Acceptable proofs that burial expenses were paid include the original itemized receipted bill or certified copy of it showing name of person or organization who paid the burial expenses; or a statement of burial expenses completed by the funeral director on RRB Form G-273a, Funeral Director's Statement of Burial Charges.

PROOF OF APPOINTMENT AS LEGAL REPRESENTATIVE – A person claiming benefits as legal representative of an estate must submit evidence of the court appointment. If appointment was made more than one year ago, the letters must carry the court's certification that they are still in full force and effect.

SOCIAL SECURITY NUMBER – Acceptable proofs include a copy of the social security card, a letter from the Social Security Administration, or other proof for social security number.

DIRECT DEPOSIT INFORMATION – The best proof is a specific document from your financial institution. This could include a voided check, Form Sf-1199a, Direct Deposit Sign-up form, or other document from your financial institution that includes the 9-digit routing number, your name, and account number. Failure to provide this information could result in a delay of payment.

PROOF OF PUBLIC SERVICE PENSION OR NON-COVERED SERVICE PENSION – Acceptable proofs should include effective dates and current amount of pension.

PUBLIC SERVICE PENSION OFFSET VERIFICATION - If your Public Service Pension employer was a State or Local government agency, acceptable proof is a letter from this employer indicating that FICA (Social Security) taxes were withheld from the last 60 months of your employment, including your last day of employment.

EMPLOYER IDENTIFICATION NUMBER (EIN) – This is a 9-digit number that can be found on Form W-2 or obtained from your last nonrailroad employer.

Application For Determination Of Employee's Disability

Do Not Write In This Space

Officially Filed

Month	Day	Year	Office Number

Approved

Date Coded

Application Number	Month	Day	Year

Coded by

Section 1 General Instructions

Before you complete this application, be sure to read Part 1 of booklet RB-1d, Employee Disability Benefits, which explains information you will need to answer many of the questions in this application. Please read "Important Notices" on page 15 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 June 6, 2016, as:

Month	Day	Year
0 6	0 6	2 0 1 6

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 5 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 James C Mills		
	2 Employee's Railroad Retirement Claim Number A 221-52-3482	3 Employee's Social Security Number 221-52-3482	
	4a Employee's Street Address 2406 HUGGINS STREET		
	b City and State/Province COLUMBUS, GA	c ZIP Code 31903	d Country
	5a Daytime Telephone Number 302-420-2076	b Alternate Telephone Number	

Section 3 Information About Your Medical Condition

Medical Condition

6 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

7 Enter the date the condition(s) **began** to affect your ability to work. ▶

Month	Day	Year

How Condition Affects Work

8 Enter an "X" in the appropriate box:
Have you worked since the date in Item 7? ▶

Yes ▶ Go to Item 9
 No ▶ Go to Item 10

9a Enter an "X" in the appropriate box:
Has your condition caused you to change any aspect of your work (such as job duties, hours of work, attendance, etc.)? ▶

Yes ▶ Go to Item 9b
 No ▶ Go to Item 10

b Explain what the changes in your work circumstances were, the dates they occurred, and why your condition(s) made these changes necessary.

CHANGES	DATES	CONDITION

When Unable To Work

10 Enter the date you could no longer work because of your condition(s). ▶

Month	Day	Year

11 Describe how your condition(s) prevents you from working.

CONSTANT PAIN

Current Work Status

12a Enter an "X" in the appropriate box:
Did you attempt to go back to work and were you unable to do so? ▶

Yes ▶ Go to Item 12b
 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

13a Enter an "X" in the appropriate box:
Have you received medical care or been examined for your condition(s) since the date in Item 7? Yes 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? Yes No **▶ Explain below**
▶ Go to Item 14

Explain: _____

Treatment
or Testing

14 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? Yes No **▶ Go to Item 15**
▶ Go to Item 16

15 Enter information about each hospital, institution, or clinic where you have received treatment or care since the date in Item 7.

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	Telephone Number (Include Area Code) ()

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	Telephone Number (Include Area Code) ()

Dates Treated or Tested	Describe Type of Treatment or Testing

Doctor Treatment (Cont)

17c Name of Physician

Address of Facility (Street Address, City, State/Province, and ZIP Code)

Patient Number

Telephone Number (Include Area Code) ()

Dates Treated or Examined

Describe Type of Treatment or Examination

Railroad Employer Examination

18 Enter an "X" in the appropriate box: Has your railroad employer referred you to a medical source for examination or treatment within 18 months of filing this application? Yes No Go to Item 19 Go to Item 20

19 Enter information about this examination or treatment.

Name of Medical Source
Attending Physician's Name

Address of Source (Street Address, City, State/Province, and ZIP Code)

Enter an "X" in the appropriate box: Inpatient Outpatient

Patient Number

Telephone Number (Include Area Code) ()

Dates Treated or Examined

Describe Type of Treatment or Examination

20 Enter an "X" in the appropriate box: Have you been medically disqualified for work by your employer? Yes No Go to Note and Item 21 Go to Item 21

Note: If answered "Yes," you must submit a copy of the Disqualification Notice.

Activity Restriction

21 Enter an "X" in the appropriate box: Has a medical doctor restricted your daily activities since the date in Item 7? Yes No Go to Item 22 Go to Item 25

22 Enter the name of the medical doctor who imposed the restriction. Also enter the medical doctor's address if it has not previously been entered in items 16, 18, or 20.

Name of Medical Doctor

Address of Medical Doctor (Street Address, City, State/Province, and ZIP Code)

23 Enter the date the restriction began.

Month Year

Activity Restriction (Cont)

24 List and describe the condition(s) and how your daily activities were restricted by the condition(s).

Medication

25a Enter an "X" in the appropriate box: Are you currently taking prescribed medication(s)? Yes ▶ Go to Item 25b No ▶ Go to Section 5

b 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. ▶

27a Enter an "X" in the appropriate box: Are you currently attending school (including online)? Yes ▶ Go to Item 27b 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.

- Technical
- Specialized
- Vocational
- Services: _____
- Other: _____

Skip Item 28 and go to Item 29b.

28 Enter the date that you last attended school. ▶

Month	Day	Year

29a Enter an "X" in the appropriate box: Have you attended technical school, or received specialized/vocational training or services? Yes ▶ Go to Item 29b 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? Yes ▶ Go to Item 31 No ▶ Go to Section 6

31 Enter an "X" in the appropriate box: Is the degree, certificate, or license you received currently valid? Yes No

32 Enter an "X" in the appropriate box: Have you used any of this training in your work? Yes ▶ Go to Item 33 No ▶ Go to Section 6

Schooling
(Cont)

33 Describe when and how you have used this training in your work.

Section 6 Information About Your Daily Activities

Activities

- 34 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 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"/>	
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"/>	

35 Describe your daily activities during a normal day (i.e., a typical day from the time you get up until you go to bed).

36a 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 36b
 No ▶ Go to Item 37

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 36d
 No ▶ Go to Item 37

d Describe the changes.

37a 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 37b
 No ▶ Go to Section 7

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? Yes ▶ Go to Item 37d
 No ▶ Go to Section 7

d Describe the changes.