

**UNION PACIFIC RAILROAD  
NON-OPERATING EMPLOYEES MONTHLY PROTECTION CLAIM FORM**

**SECTION I: PERSONAL INFORMATION (FILLED OUT BY CLAIMANT)**

DATE		CLAIMANT NAME (LAST, FIRST, MI)		EMPLOYEE ID	
MAILING ADDRESS			HOME PHONE (     )		DATE RECEIVED [DEPT USE ONLY]
CITY	STATE	ZIP CODE	WORK PHONE (     )		PROT. ROSTER [DEPT USE ONLY]
CURRENT OR LAST WORK LOCATION			JOB POSITION		PROT. TYPE [DEPT USE ONLY]

**SECTION II: CLAIM INFORMATION (FILLED OUT BY CLAIMANT)**

MONTH BEING CLAIMED (MONTH & YEAR)	AGREEMENT TYPE (CHECK ONE)				FURLOUGHED (CHECK ONE)	
	FEB7 <input type="checkbox"/>	NYD <input type="checkbox"/>	ME64 <input type="checkbox"/>	OSL <input type="checkbox"/>	ALL MONTH <input type="checkbox"/>	PARTIAL MONTH <input type="checkbox"/>

UNEMPLOYMENT BENEFITS CLAIMED	\$	NAME OF OUTSIDE EMPLOYER
EARNINGS FROM RAILROAD RETIREMENT	\$	
EARNINGS FROM OTHER (OUTSIDE) EMPLOYMENT	\$	

**SECTION III: DAILY WORK RECORD (FILLED OUT BY CLAIMANT)**

USE THE BELOW LISTED CODES FOR EACH DAY OF THE MONTH YOU ARE CLAIMING

AV-AVAILABLE F-FURLOUGHED	H-HOLIDAY L-LEAVE OF ABSENCE	MC-MISSED CALL NP-UNPAID ABSENCE	NQ-NOT QUALIFIED O-OTHER AVAILABLE DAYS R-REST DAY	S-SICK V-VACATION W-WORKED
1	7	13	19	25
2	8	14	20	26
3	9	15	21	27
4	10	16	22	28
5	11	17	23	29
6	12	18	24	30
				31

NOTE: ALL TIME LOST, VOLUNTARY AND REFUSED OVERTIME MUST BE REPORTED BY THE TIMEKEEPER

**SECTION IV: TO BE COMPLETED BY LAST SUPERVISOR**

DID EMPLOYEE PASS UP AN OPPORTUNITY TO PERFORM SERVICE DURING THE PERIOD CLAIMED?	Y <input type="checkbox"/>	N <input type="checkbox"/>
ARE YOU AWARE OF ANY OUTSIDE EMPLOYMENT OBTAINED BY CLAIMANT?	Y <input type="checkbox"/>	N <input type="checkbox"/>
ARE YOU AWARE OF ANYTHING THAT MAY HAVE LIMITED THE CLAIMANT'S AVAILABILITY, SUCH AS HOSPITALIZATION, ILLNESS, ETC.?	Y <input type="checkbox"/>	N <input type="checkbox"/>
SUPERVISOR'S NAME	SUPERVISOR'S PHONE NO.	SUPERVISOR'S SIGNATURE

**I HEREBY CERTIFY THAT THE INFORMATION SHOWN ON THIS FORM IS TRUE AND CORRECT AND THAT I AM PHYSICALLY QUALIFIED TO PERFORM SERVICE.**

*(FORM MUST BE SIGNED AND DATED BY EMPLOYEE CLAIMING BENEFITS TO ENSURE ACCURATE PROCESSING)*

EMPLOYEE'S SIGNATURE	DATE
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PLEASE FAX OR MAIL YOUR COMPLETED FORM ON THE 1ST BUSINESS DAY FOLLOWING THE MONTH YOU ARE CLAIMING

MAIL TO: UPRR PROTECTION MANAGEMENT 1400 DOUGLAS STREET STOP 0710 OMAHA, NEBRASKA 68179-0710	COMM FAX: (402) 501-0117 CO FAX: (8) 501-0117	QUESTIONS?? PLEASE CALL <b>(888) 634-0441</b>
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