

**UNION PACIFIC RAILROAD  
FURLOUGHED 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
CURRENT OR LAST WORK LOCATION		JOB POSITION	
		PROT. ROSTER [DEPT USE ONLY]	
		PROT. TYPE [DEPT USE ONLY]	

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

MONTH BEING CLAIMED (MONTH & YEAR)	FURLOUGHED (CHOOSE ONE)	
	ALL MONTH	PARTIAL MONTH
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	H-HOLIDAY	MC-MISSED CALL	NQ-NOT QUALIFIED	S-SICK
F-FURLOUGHED	L-LEAVE OF ABSENCE	NP-UNPAID ABSENCE	O-OTHER AVAILABLE DAYS	V-VACATION
			R-REST DAY	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 EMAIL, 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	EMAIL: jeeisele@up.com FAX: (402) 501-0117	QUESTIONS?? PLEASE CALL <b>(402) 544-1005</b>
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