NOTICE OF DISABILITY FORM

Supplemental Sickness Benefit Plan

AETNA DISABILITY WORKABILITY

P.O. BOX 14560
LEXINGTON, KY 40512-4560
PHONE: (800) 205-7651
FAX: (866) 667-1987

AETNA is the claim administrator for your Railroad Supplemental Sickness Benefit Plan
Within 60 days of your first day absent from work call 1-800-205-7651 or complete & mail or fax this form.

SECTION I THIS SECTION MUST BE COMPLETED BY OR ON BEHALF OF THE EMPLOYEE FOR ALL CLAIMS

Name of Employee (Please Print)	Date of Birth	Social Security Number	Employee Number
Employee's Address (Street) (City) (State) (Zip)		Telephone Number ( )	Hire Date

Name of Employer

Department Last Worked | Location Last Worked

Date You Last Worked | Next Scheduled Work Day

Indicate which Organization represents you: ___ARASA

- ❐ Maintenance of Way ❐ Electrical Workers ❐ Boilermakers, etc.
- ❐ Signalmen ❐ Railway Carmen ❐ Firemen & Oilers
- ❐ Machinists & Aerospace ❐ Sheet Metal Workers ❐ Other ____________

Rate of Pay (per hr./ per month) $

Occupation

Date You Became Disabled

Supervisor's Name | Telephone No. ( )

Name of All Treating Physicians | Telephone No.
1. ( )
2. ( )
3. ( )
4. ( )

Indicate Cause of Disability ❐ Accident (Complete Part II) ❐ Sickness

Have you returned to work? ❐ Yes ❐ No
- If Yes, provide your return to work date ____________
- If No, when do you expect to return to work? ____________

Have you received vacation pay since your last day worked? ❐ Yes ❐ No
- If Yes, provide date(s) ____________

Date of First Treatment

Do you hold any of the following certifications? ❐ Yes ❐ No
❐ DOT ❐ CRANE ❐ CDL ❐ Other ____________
- If Yes, Have you been medically certified to return to work? ❐ Yes ❐ No

Have you completed a total of at least 12 calendar months of employment with one or more participating railroads? ❐ Yes ❐ No

Did you work for the Employer named above (or take vacation with pay) in the month before you became disabled? ❐ Yes ❐ No

SECTION II TO BE COMPLETED ONLY IF ACCIDENT INVOLVED

Date of Accident

Were you at work when accident happened? ❐ Yes ❐ No
If yes, for whom? ____________

Explain how accident happened?

Was a railroad off-track vehicle involved? ❐ Yes ❐ No

Did injury result from a traffic accident? ❐ Yes ❐ No

Will a liability claim be made? ❐ Yes ❐ No

SECTION III THIS SECTION MUST BE COMPLETED BY OR ON BEHALF OF THE EMPLOYEE FOR ALL CLAIMS

Benefits under the Railroad Unemployment Insurance Act:

1. Have you applied for sickness benefits under the Railroad Unemployment Insurance Act? ❐ Yes ❐ No
2. If not, why not? ❐ I am not qualified under the Act ❐ My benefits have exhausted for this benefit year
   ❐ Other ____________

Other Income Benefits:

1. Are any of the "Other Income Benefits" listed below available to you while disabled? ❐ Yes ❐ No
   (If yes, check each of the following that apply, and show the monthly amounts payable)

- ❐ Railroad Retirement Act – Disability Annuity $ ________
- ❐ Social Security Act ❐ Because of Age ❐ Because of Disability $ ________
- ❐ Military Pension ❐ Because of Years of Service ❐ Because of Disability $ ________
- ❐ Wage Continuation $ ________
- ❐ Off-Track Vehicle Agreement $ ________
- ❐ Protective Agreement $ ________
- ❐ Advancement from possible settlement with Railroad $ ________
- ❐ Any other plan toward the cost of which any employer has contributed. (Specify) ____________

FRAUD STATEMENT

If your application for benefits includes information that you know is false or misleading, you may be subject to criminal and civil penalties for fraud. Penalties may include imprisonment, fines, and denial of benefits. You may also be required to pay damages and could be subject to discipline by your employing railroad.

EMPLOYEE SIGNATURE: ____________________ DATE: ____________

You may file your claim over the telephone by calling: 1-800-205-7651, by mail, fax, or via the World Wide Web by logging onto: https://www.wkabsystem.com