

TRUSTMARK INSURANCE COMPANY

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NOTICE OF DISABILITY

UTU Yardmasters – Employees Supplemental Sickness Benefit Plan

IMPORTANT INSTRUCTIONS – To apply for benefits, complete all sections of this form so your eligibility can be confirmed. You should also complete an “Application for Sickness Benefits” and send it to the U. S. Railroad Retirement Board for RUIA Sickness Benefits.

SECTION I. This section must be completed by or on behalf of the covered employee for all claims.

Name of Employee (Please Print)			Name of Employing Railroad		Employee No.	Social Security No.	
Employee's Home Address (Number)		(Street)	Division and Location Last Worked		Occupation		Rate of Pay (per hr./per mo.)
(City)	(State)	(Zip)	When did you become disabled? <input type="checkbox"/> A.M. (Month) (Day) (Year) <input type="checkbox"/> P.M.		Cause of Disability? <input type="checkbox"/> On duty injury <input type="checkbox"/> Off duty injury <input type="checkbox"/> Sickness		
Indicate Which Organization Represents You <input type="checkbox"/> UTU Yardmasters <input type="checkbox"/> Other			Date Employed		Date of Birth		Age
Status in Month Before Disability Commenced: <input type="checkbox"/> Worked <input type="checkbox"/> On vacation with pay <input type="checkbox"/> Other (explain)				Date You Last Worked Prior to Disability			
Why did you stop working? (Check one) <input type="checkbox"/> Disability <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Retired <input type="checkbox"/> Other (Explain) <input type="checkbox"/> Furlough <input type="checkbox"/> Discharged <input type="checkbox"/> Resigned							Home Phone # ()
Name of Doctor?		Date of First Treatment (Month) (Day) (Year)		Have you returned to work? <input type="checkbox"/> Yes – If so, give date _____ <input type="checkbox"/> No – If not, when do you expect to return to work? _____			
Have you received vacation pay since the date you became disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No If “Yes”, show dates between which you received vacation pay: From _____ To _____							

SECTION II. This section must be completed by or on behalf of the covered employee for all claims.

Date of Accident (Month) (Day) (Year)		<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Were you working when the accident happened? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, for whom?				
Explain how accident happened?							
Was a railroad off-track vehicle involved? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did Injury result from a Traffic Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No			Will a Liability Claim be made? <input type="checkbox"/> Yes <input type="checkbox"/> No		

SECTION III. This section must be completed by or on behalf of the covered employee for all claims.

Benefits under the Railroad Unemployment Insurance Act:

Have you applied for sickness benefits under the Railroad Unemployment Insurance Act?..... Yes No

If not, why not?

- Am not qualified under the Act.
- Have not had a disability lasting four consecutive days or more this benefit year.
- My benefits have been exhausted for this benefit year
- Other (explain).

Other Income Benefits:

Are any of the “Other Income Benefits” listed below available to you while disabled?..... Yes No
(If so, check each of the following which is applicable, and show monthly amounts payable.)

- Railroad Retirement Act – Disability Annuity..... \$ _____
- Social Security Act..... \$ _____
- Any other government or tax-supported plan, federal, state or local..... \$ _____
- Any other plan toward the cost of which any employer contributed..... \$ _____

If you received an Annuity on a retroactive basis for a part of a Period of Disability for which benefits were paid under this Plan, Trustmark will have the right to recover the amount of benefits paid you which are in excess of the amount you would have received had we known of the Annuity prior to our payment. Please contact Trustmark Insurance Company when you apply for an annuity

