# SUPPLEMENTAL SICKNESS BENEFIT PLAN FOR RAILROAD YARDMASTER EMPLOYEES


Provided Under Group Contract 9000
Issued by Trustmark Insurance Company
January 1, 2010

# FOREWORD

This booklet provides a summary description of the Supplemental Sickness Benefit Plan for Railroad Yardmaster Employees (the “Plan”) as in effect on January 1, 2010, under collective bargaining agreements between railroads represented by the National Carriers' Conference Committee and employees represented by the United Transportation Union - Yardmaster Department.

Plan benefits are fully insured by Trustmark Insurance Company ("Trustmark") under Group Policy 9000 issued to the railroads listed in Exhibit C to such Policy. Those railroads collectively constitute the Policyholder and are represented in such capacity by the National Carriers' Conference Committee.

# HOW TO FILE A CLAIM

## WITH TRUSTMARK

(1) The Plan provides benefits for disability, beginning on the fifth consecutive day of disability. Therefore, you and your attending physician should fully complete all parts of the "Notice of Disability" form and send it to Trustmark as soon as you know your disability will last more than four consecutive days. Be sure your attending physician totally completes all items in Section IV of the form.

(2) After you have been paid benefits for any disability during the first fourteen days, a green "Proof of Disability" Form I363-18R98 will be sent to you. Use the instructions provided on the form for completion.

(3) Address all correspondence to:

**Trustmark Insurance Company**
**P. O. Box 7901**
**Lake Forest, IL 60045-7901**

The Notice of Disability and Proof of Disability forms may be faxed to Trustmark. The fax number is **847-615-4948**. If you have any questions about filing your claim, please call **1-800-504-9052**.

## WITH THE U.S. RAILROAD RETIREMENT BOARD

(1) Obtain Forms SI-1a and SI-1b, Application for Sickness Benefits and Statement of Sickness from your employer, local Railroad Retirement Board office, or your union representative.

(2) Have your doctor complete the Form SI-1b, Statement of Sickness. The form then is to be mailed on or before the 7th day following your first day of disability to the Bureau of Unemployment and Sickness Insurance, U.S. Railroad Retirement Board, 844 Rush Street, Chicago, Illinois 60611. If you do not file within the 7 days, you may lose benefits.

(3) After you've made proper application to the Railroad Retirement Board, you will be sent a new claim card (Form SI-3) to complete approximately every 14 days.

If you have any questions about filing for your Railroad Unemployment Insurance Act (RUIA) sickness benefits, contact your local Railroad Retirement Board office.

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# SECTION I – SCHEDULE OF BENEFITS

**BENEFITS START:** 5th Consecutive Day of Disability

*During any period in which you are eligible for RUIA Sickness Benefits, in order to receive benefits under this Plan, you must also apply for and be approved for RUIA Sickness Benefits. You cannot receive benefits under the Plan for any period in which you are eligible to receive RUIA Sickness Benefits if you fail to apply for those Sickness Benefits or if you are denied those benefits for any reason. The first period in which you can receive Plan benefits is your initial RUIA Sickness Benefits registration period.*

**MAXIMUM BENEFIT PERIOD:** 12 Months

## BASIC BENEFIT AMOUNT

For Periods of Disability Starting On or After January 1, 2010

| | For Insured Employees Who Have Not Received Maximum Sickness Benefits Under RUIA* in the Benefit Year Involved | | For Insured Employees Who Have Received Maximum Sickness Benefits Under RUIA* in the Benefit Year Involved | |
|---|---|---|---|---|
| **Class** | **Per Month** | **Per Day**** | **Per Month** | **Per Day**** |
| Class 051 | $1,941.00 | $64.70 | $3,333 | $111.10 |

* **"RUIA"** means the Railroad Unemployment Insurance Act.

**The rate "per day" shown above is the monthly rate divided by 30. It applies to disabilities lasting less than a month or to the extra days for disabilities lasting more than an exact number of months.

**An Insured Employee during his initial RUIA registration period after all certification requirements are met will receive: (i) benefits for the 5th through the 14th day of disability at the applicable Basic Benefit Amount shown above, plus (ii) an amount equal to the total RUIA benefit that would have been payable for days of sickness except for RUIA's "waiting period" requirement. Benefit payments after that will be made monthly. A "month" is any period from a date in one month to the same date in the next month.**

The Basic Benefit Amount shown above will be reduced so that it, together with other income benefits, will not be more than the Maximum

## SECTION I – SCHEDULE OF BENEFITS

Monthly Amount shown on Page 8. Other income benefits include those payable under RUIA and others listed on Pages 9 and 10.

**The benefits shown in the booklet apply only to Periods of Disability which start on or after January 1, 2010. Contact Trustmark for information about benefits applicable to Periods of Disability which began prior to January 1, 2010.**

## SECTION II – ELIGIBILITY AND TERMINATION OF COVERAGE

**Eligibility**

Generally speaking, you are eligible for the coverage under this Plan while you are an "Insured Employee". To be an Insured Employee, you must fall within all three of the definitions set forth below. These are the definitions of Employee, of Qualified Employee and of Insured Employee.

**"Employee"** means an individual who:

(1) is employed by a participating railroad; and

(2) is represented by the United Transportation Union – Yardmaster Department.

**"Employee"** also includes:

(1) any other yardmaster employee of a participating railroad if the railroad has made the required premium payment; and

(2) any General Chairman or other full-time labor representative of the United Transportation Union-Yardmaster Department if appropriate premiums are paid through that labor organization.

**"Qualified Employee"** means an Employee who:

(1) has completed 30 days of continuous employment with the same participating railroad in a position represented by the United Transportation Union - Yardmaster Department, or other participating labor organization, and is covered by its schedule agreement; and

(2) is a Qualified Employee as that term is defined in Section 3 of the Railroad Unemployment Insurance Act as it now is or may later be amended.*

*Section 3 of RUIA (effective with base year 2009) states:

> "An employee shall be a 'qualified employee' if the Board finds that his compensation with respect to the base year will have been not less than $3,325.00 and, if such employee has had no compensation prior to such year, that he will have had compensation with respect to each of not less than five months in such year."

The term "base year" means the calendar year right before the start of a benefit year. The term "benefit year" means the twelve month period starting on July 1 of any year and ending on June

**Eligibility**

30 of the next year. Thus, the base year for benefit year 2010 (July 1, 2010 to June 30, 2011) is calendar year 2009.

In arriving at the $3,325.00 base year compensation for benefit year 2010 (July 1, 2010 – June 30, 2011), only the first $1,330.00 of compensation in any month is counted.

In sum, an Employee who has satisfied paragraphs (1) and (2) above will be a Qualified Employee as of the first day of the benefit year that begins on July 1st next following the end of the base year in which the employee satisfies the RUIA's compensation standard.

Paragraph (1) above of the definition of Qualified Employee will not apply if an Employee who is furloughed by his employing railroad while covered under the Plan starts to work for another participating railroad while still covered.

**"Insured Employee"** means a Qualified Employee who, under a schedule agreement held by the United Transportation Union - Yardmaster Department, or another participating labor organization, during any calendar month:

(1) renders compensated service for a participating railroad; or
(2) receives vacation pay from a participating railroad.

The Qualified Employee will be an Insured Employee in any month only if he rendered compensated service or received vacation pay during the prior month, except that if he:

- becomes disabled while an Insured Employee, and
- continues to be disabled,

he can continue to remain eligible for benefits for that disability, subject to other limitations on Plan benefits, even though, as a result of that disability, he does not render compensated service or receive vacation pay during the prior month.

A Qualified Employee who is no longer an Insured Employee due to disability, furlough, leave of absence or discharge will again be an Insured Employee on the date he again begins to render compensated service for a participating railroad, provided that the Employee:

(a) again begins to render compensated service within 12 calendar

**Eligibility**

months after he is no longer an Insured Employee; and

(b) renders compensated service under a schedule agreement held by the United Transportation Union - Yardmaster Department or other participating labor organization.

Such Employee will be an Insured Employee for the rest of that calendar month.

A Qualified Employee who no longer renders compensated service may continue to be an Insured Employee if his employing railroad:

(a) has to provide continued Plan benefits under compensation maintenance provisions of an agreement, a statute, or an order of a regulatory authority; and

(b) keeps on making the same premium payments as if the Employee had rendered compensated service.

**"Vacation Pay" received after an Employee is furloughed or ceases to maintain his employment relationship with a participating railroad will not continue Plan coverage.**

# SECTION II – ELIGIBILITY AND TERMINATION OF COVERAGE

**Termination of Coverage**

Your coverage will end on the sooner of:

(a) the date the Plan ends;
(b) the date your employing railroad or Labor Union no longer participates in the Plan;
(c) the date the Plan is changed to end the coverage for the class of Employees of which you are a member; or
(d) the date you are no longer an Insured Employee as defined on Pages 2 - 4.

**Return to Work**

When an Insured Employee's physician determines that the Employee is no longer Totally Disabled (as that term is defined on Page 6) and the Employee is medically qualified to return to work, and the carrier's designated medical officer finds in his medical judgment that such employee is not medically qualified to return to work, the Employee shall be promptly notified by the employing railroad. The Employee's disability payments due under the Plan shall continue until the sooner of the date the Employee is found to be medically qualified to return to service by the carrier's designated medical officer or the expiration of the twelve-month limitation on Plan benefits for such disability.

Nothing contained herein shall be construed to extend the amount or duration of payments under the Plan to any employee beyond that currently provided.

# SECTION III – BENEFIT PROVISIONS

**Benefits Payable**

Benefits will be paid to you if you become Totally Disabled due to accident or sickness subject to the following:

(1) The Period of Disability must start while you are an Insured Employee.
(2) You must be certified Totally Disabled by a legally qualified physician.
(3) Benefits are subject to all the terms, conditions, limitations and exclusions of the Plan.

Benefits start on the fifth (5th) consecutive day of Total Disability and will be paid monthly while a Period of Total Disability continues, except as provided on Page 1.

**"Total Disability"** or **"Totally Disabled"** means that because of an accident or sickness:

(1) a legally qualified physician is giving you care which is appropriate for the nature of the condition. (Trustmark will waive this requirement when continued care would be of no benefit to you); and
(2) you are unable to perform:
    (a) the duties of any job available to you in your craft; or
    (b) the duties of the last job on which you worked before your disability began, if there is no job available to you in your craft.

**"Period of Total Disability "** means a period of time during which you are Totally Disabled from one or more causes. It starts the first full day of Total Disability after you stop rendering compensated service for your employing railroad. The Period of Disability ends on the sooner of:

(1) the date you are no longer Totally Disabled; or
(2) the date you go back to active work for any employer.

**Successive Periods of Disability**, whether or not your Total Disability started while you were an Insured Employee, will be considered one Period of Disability unless the later period:

(1) is separated by a period of 90 consecutive calendar days during which you have worked on a full time basis; or
(2) is due to an entirely unrelated cause and begins after you have returned to compensated service on a full time basis for at least one day.

## SECTION III – BENEFIT PROVISIONS

**Benefits Payable**

**Termination of Benefits** – Benefits for your Total Disability will end on the sooner of:

(1) the date of your death;
(2) the date you are no longer Totally Disabled; or
(3) the date you have qualified for benefits for 12 months for your Total Disability, subject to item (j) under Limitations and Exclusions on Page 11.

**Employees Paid in Ca nadian Funds** - Dollars and cents for an employee paid by a railroad in Canadian funds will mean dollars and cents in Canadian funds. Payments made to these employees in United States funds under RUIA, other laws or private plans, will be converted to their Canadian equivalents when reductions are made as provided on Pages 9 and 10 if the value of the Canadian dollar varies by more than one cent from the value of the United States dollar.

**Local Agreements** – The benefits of Insured Employees represented by Labor Unions which have entered into local agreements with a participating railroad will be determined by the wage increases provided for under the national agreements with that union, if the Railroad is required to make the same contribution for this Plan as that made by the Railroads who are parties to the applicable national agreements.

# SECTION III – BENEFIT PROVISIONS

**Amount of Benefits**

The amount of the monthly Plan benefit is the "Basic Benefit Amount" reduced by the "Reductions Applicable to Basic Benefit Amount" shown on Pages 9 and 10. The Basic Benefit Amount is figured according to "Part 1 - Basic Benefit Amount" below.

**Part I-Basic Benefit Amount**

The Basic Benefit Amounts shown in SECTION I - SCHEDULE OF BENEFITS are payable for Periods of Disability beginning on or after January 1, 2010, subject to the following:

1. The benefit rate will not change to the larger Basic Benefit Amount during any Period of Disability unless the Insured Employee uses all of his sickness benefits under RUIA during a benefit year. Likewise, if during any Period of Disability a new benefit year under RUIA starts and if the Insured Employee whose sickness benefits had been used up is again qualified for benefits, the benefit rate under this Plan will be changed to the lower Basic Benefit Amount.
2. If during any Period of Disability a new benefit year under RUIA starts and the Insured Employee whose benefits had been used up is not qualified and eligible to again receive sickness benefits under RUIA, the benefits under this Plan will be payable at the lower Basic Benefit Amount.

If RUIA is changed to increase the amount of sickness benefits payable, so that the sum of

(a) 21.75 times the average daily sickness benefits under RUIA, plus

(b) the Basic Benefit Amount provided for you while receiving sickness benefits under RUIA

is more than the Maximum Monthly Amount shown below, your Basic Benefit Amount will be reduced by an amount equal to the amount by which (a) plus (b) is more than the Maximum Monthly Amount.

**Maximum Monthly Amount**

$3,502.00

The Basic Benefit Amount payable under this Plan will also be reduced if it together with RUIA sickness benefits and other benefits shown in Part II is more than the Maximum Monthly Amount.

## SECTION III – BENEFIT PROVISIONS

**Amount of Benefits**

**Part II-Reductions Applicable to Basic Benefit Amount**

1. If you are entitled to benefits under this Plan and receive any of the payments in (1), (2), (3) or (4) below for any part of the same period of time, your Basic Benefit Amount will be reduced. The Basic Benefit Amount will be reduced by the amount that the sum of

   (a) your Basic Benefit Amount; plus

   (b) other payments described in (1), (2), (3) or (4) below; plus

   (c) sickness benefits payable under RUIA;

   is more than the Maximum Monthly Amount shown above. Other payments include:

   (1) annuity payments under the Railroad Retirement Act;

   (2) benefit payments under Title II of the Federal Social Security Act;

   (3) unemployment, maternity or sickness benefits under any unemployment, maternity or sickness compensation law other than RUIA; and

   (4) any other social insurance payments under any law.

   If you do not receive sickness benefits under RUIA because of the provisions of Section 4 (a-1) (ii) of such Act*, the Basic Benefit Amount, reduced as provided above, will be paid. Item (k) under Limitations and Exclusions on Page 11 will not affect this provision.

   *Section 4(a-1) (ii) of RUIA provides that you will be disqualified for benefits for any day for which you receive unemployment, maternity, or sickness payments under another law. If you receive payments as described in (1), (2), or (4) above, they will be offset against your payments under RUIA.

   If you receive any payments described in (1), (2), (3), or (4) retroactively for a period for which benefits were paid under this Plan, Trustmark may get back any excess benefits it has paid. The amount returned will be the difference between the benefits actually paid under the Plan and the lesser amount that would have paid under the Plan had the retroactive payments been made before the Plan's benefits were paid.

**Amount of Benefits**

2. If you are eligible for benefits for a disability under any other plan, fund or arrangement by any name for which an employer has contributed, the Basic Benefit Amount will be reduced so that the sum of

   (a) the benefits for which you are eligible under other plans, funds or arrangements; plus

   (b) your sickness benefits under RUIA; plus

   (c) the Basic Benefit Amount;

   will not be more than the Maximum Monthly Benefit Amount as shown on Page 8. A plan, fund, or arrangement includes but is not limited to:

      (i) any group life policy providing installment payments for permanent total disability;

      (ii) any group annuity contract;

      (iii) any pension or retirement annuity plan; or

      (iv) any group accident and health insurance paying loss of employment time benefits for disability.

      (v) any employer sick leave or wage continuation program; or

      (vi) any loan arrangement between employee and employer where the employer has a right of recovery.

3. If you are disabled in an off-track vehicle accident covered under applicable provisions of the national agreements, the Basic Benefit Amount will be reduced by the amount of any payment made to you by reason of that coverage for time loss for the same disability.

**Limitations and Exclusions**

No benefits will be paid under this Plan:

(a) for the first four consecutive days of any Period of Disability;

(b) for more than 12 months during any Period of Disability, subject to item (j) below;

(c) for any period during which you are not certified as receiving treatment by a legally qualified physician;

(d) for any day you render compensated service or otherwise work for or receive pay from any employer;

(e) for any disability which begins after you have started work on a regular or permanent basis for a participating railroad other than on a position coming under a schedule agreement held by the participating labor union (covered position) unless the last position on which you worked before the start of your disability was a covered position;

(f) for any disability due to intentionally self-inflicted injury or sickness;

(g) for any disability caused by you committing or attempting to commit an assault, battery or felony;

(h) for any disability due to war or act of war (whether war is declared or not), insurrection or rebellion, or your participation in a riot or civil commotion;

(i) for any disability starting after your employment with the participating railroad has ended. This exclusion will not apply if you are an Insured Employee and you leave the service of one participating railroad and, without missing more than one week of work, start work for another participating railroad on which you are already a Qualified Employee and for that reason end your employment with the former railroad;

(j) for any period for which you receive vacation pay during a disability. (This Plan's disability benefit period will be extended beyond 12 months by the number of days for which benefits are denied because of vacation pay); or

(k) for any period for which you are eligible to receive disability benefits under RUIA but are denied benefits for any reason including your failure to apply.

## AUTHORIZATION TO DISCLOSE/RELEASE OR OBTAIN MEDICAL RECORDS

All disclosures are in compliance with Federal and State laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), governing the use and disclosure of Protected Health Information (PHI).

Patient Name: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____ Date of Birth: _____

I authorize: _____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

Release to: **Trustmark Insurance Company**
**P.O. Box 7901**
**Lake Forest, IL 60045-7901**

Specify Dates or date ranges: _____

Protected Health Information (PHI) includes individually identifiable health information that is created or received by my provider, my health plan or insurer, a data clearinghouse, a health authority, employer, school, or university. PHI can be maintained or transmitted in any form or medium. It relates to the past, present, or future:

- Condition of my physical or mental health;
- Healthcare provided to me; or
- Payment for the healthcare provided to me.

PHI does not include summary health information or information that has been de-identified according to the standards for de-identification provided in the HIPAA Privacy Rule.

I authorize any licensed physician, medical practitioner, medical professional, psychologist, counselor, hospital, clinic, including Veterans Administration, or other medically related facility, pharmacy, government agency, Social Security Administration, insurance company, insurance support organization, employer, or any other holder of my personal health information documents, to release to **Trustmark Insurance Company** (herein as referred to "the Company") or its authorized representative, all requested information or records. This shall include but not be limited to, any information and health history including all consultation, diagnosis, prescriptions, treatments, tests as well as any information regarding

# ATTENDING PHYSICIAN'S STATEMENT

**Return To:** Trustmark Insurance Company
P.O. Box 7901
Lake Forest, IL 60045-7901
Phone 1.800.504.9052 • Fax 847.615.4948

| Name of Patient | Date of Birth |
|---|---|
| | |

**HISTORY**

(a) When did symptoms first appear or accident happen?

(b) Date patient ceased work because of disability?

(c) Has patient ever had same or similar condition? ☐ Yes ☐ No
If "Yes", state when and describe.

(d) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

(e) Names and addresses of other treating physicians

**DIAGNOSIS**

(a) Diagnosis (Including complications)

(b) If pregnancy, est. date of delivery

(c) Subjective symptoms

(d) Objective findings (Including current x-rays, EKG's, laboratory data and any clinical findings)

**TREATMENT**

(a) Date of first visit

(b) Date of last visit

(c) Frequency: ☐ Weekly ☐ Monthly ☐ Other (Specify)

(d) Nature of treatment (Including surgery and medications prescribed, if any)

(e) Specific restrictions and limitations

**PROGRESS**

(a) Has patient? ☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed?

(b) Is patient? ☐ Ambulatory? ☐ House Confined? ☐ Bed Confined? ☐ Hospital Confined?

(c) Has patient been hospital confined? ☐ Yes ☐ No If yes, give name and Address of Hospital

Confined from_____ through_____

**CARDIAC**

(a) Functional Capacity (American Heart Association)

☐ Class 1 (No Limitation) ☐ Class 2 (Slight Limitation)
☐ Class 3 (Marked Limitation) ☐ Class 4 (Complete Limitation)

(b) Blood Pressure (Last Visit)

_____
Systolic/Diastolic

(a) Physical Impairments (*As defined in Federal Dictionary of Occupational Titles)

☐ Class 1 - No limitation of functional capacity; capable of heavy work*. No restrictions. (0-10%)
☐ Class 2 - Medium manual activity*. (15 - 30%)
☐ Class 3 - Slight limitation of functional capacity; capable of light work*. (35 - 55%)

**Fraud Statement for Alaska Residents**

A person who knowingly and with intent to injure, defraud or deceive an insurance company, files a claim containing false, incomplete or misleading information may be prosecuted under state law.

## Fraud Statement for Arizona Residents

For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**Fraud Statement for California Residents**

**For your protection, California law requires the following to appear: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.**

**Fraud Statement for Colorado Residents**

**It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies**.

**Fraud Statement for Florida Residents**

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**Fraud Statement for Kansas, Oregon, and Vermont Residents**

Any person who knowingly, and with the intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud, which may be a crime.

**Fraud Statement for Kentucky Residents**

A person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Fraud Statement for Arkansas, Louisiana, Texas, and West Virginia**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Fraud Statement for Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or**

# TRUSTMARK INSURANCE COMPANY

P.O. BOX 7901 ◆ LAKE FOREST, IL 60045-7901 ◆ 1-800-504-9052 ◆ FAX # 847-615-4948


## 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? ☐ A.M. (Month) (Day) (Year) ☐ P.M. | Cause of Disability? ☐ On duty injury ☐ Off duty injury ☐ Sickness |
|---|---|---|
| | | |

| Indicate Which Organization Represents You ☐ UTU Yardmasters ☐ Other | Date Employed | Date of Birth | Age |
|---|---|---|---|
| | | | |

| Status in Month Before Disability Commenced: ☐ Worked ☐ On vacation with pay ☐ Other (explain) | Date You Last Worked Prior to Disability |
|---|---|
| | |

| Why did you stop working? (Check one) ☐ Disability ☐ Furlough ☐ Leave of Absence ☐ Discharged ☐ Retired ☐ Resigned ☐ Other (Explain) | Home Phone # ( ) |
|---|---|
| | |

| Name of Doctor? | Date of First Treatment (Month) (Day) (Year) | Have you returned to work? ☐ Yes – If so, give date _____ ☐ No – If not, when do you expect to return to work? _____ |
|---|---|---|
| | | |

Have you received vacation pay since the date you became disabled? ☐ Yes ☐ 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.**

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

| Date of Accident (Month) (Day) (Year) ☐ A.M. ☐ P.M. | Were you working when the accident happened? ☐ Yes ☐ No<br>If so, 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 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.**

**benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

**Fraud Statement for Minnesota Residents** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**Fraud Statement for District of Columbia, Maine, Tennessee and Virginia**
**WARNING: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.**

**Fraud Statement for New Hampshire Residents**
Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided under RSA 638:20.

**Fraud Statement for New Mexico and Pennsylvania Residents**
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES ANY APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**Fraud Statement for New Jersey** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**Fraud Warning for Delaware, Idaho, Indiana, Ohio, and Oklahoma. As Well as for the Residents of All States Not Specifically Listed**
WARNING: Any person who knowingly, and with the intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud, which is a felony.

**Fraud Warning for NY Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**

The information that I have provided on this claim form is true and complete to the best of my knowledge and belief

_____ _____

Signature of Employee Date

**IMPAIRMENTS**

☐ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60 - 70%)
☐ Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary*) activity. (75 - 100%)

Remarks:_____

(b) Mental Impairments (If Applicable)
(a) Please define "stress" as it applies to this claimant.
(b) What stress and problems in interpersonal relations has claimant had on job?

☐ Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations)
☐ Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
☐ Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
☐ Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
☐ Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Remarks:

**PROGNOSIS**

(a) Is patient now totally disabled? PATIENT'S JOB ☐ Yes ☐ No; ANY OTHER WORK ☐ Yes ☐ No

(b) Date patient became disabled due to present illness

(c) When do you expect a fundamental or marked change in the future?
☐ 1 Month ☐ 1 - 3 Months ☐ 3 - 6 Months ☐ Never Applies To: ☐ Patient's Job ☐ Other Work

**REHAB**

(a) Is patient a suitable candidate for occupational rehabilitation? PATIENT'S JOB ☐ Yes ☐ No; ANY OTHER WORK ☐ Yes ☐ No

(b) Can present job be modified to allow for handling with impairment? ☐ Yes ☐ No

(c) When could trial employment commence? Date: _____ (PATIENT'S JOB) ☐ Full-Time ☐ Part-Time Date: _____ (ANY OTHER WORK) ☐ Full-Time ☐ Part-Time

**REMARKS**

Reason unable to work, in detail

| Name (Attending Physician) Print | Degree | Telephone | |
|---|---|---|---|
| Street Address | City or Town | State or Province | Zip Code |
| Signature | Tax identification # | Date | |

drug and alcohol abuse. This shall also include any information pertaining to the treatment of mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics. In addition, I authorize any employer, former employer, insurance company or insurance support organization to give any information or record it has about me, my employment, my employment history and income earnings to the Company.

*Redisclosure Notice:* I understand the information used or disclosed based on this authorization may possibly be redisclosed by the recipient, and/or may no longer be protected by Federal Privacy standards. I understand this information will be used to determine my eligibility for benefits and may be reviewed by claims, underwriting, legal or other Company personnel. I authorize the Company to release any such information to the following persons or organizations: reinsuring companies, persons or organizations performing business, legal or medical services related to the policy or claim, or any other public or private entity as may be lawfully required. The information provided to **Trustmark Insurance Company,** its subsidiaries or representatives is to be used solely for the administration of claim(s). A simulated, faxed or copied image of this authorization shall be as valid as the original.

*Right to Inspect or Copy the Health Information to Be Used or Disclosed:* I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form.

*Right to Refuse to Sign This Authorization:* I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for healthcare benefits, on my decision to sign this authorization. I understand that if I agree to sign this authorization, I will be provided with a copy upon request.

I understand that any person who knowingly, and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information, may be guilty of a crime or insurance fraud and may be subject to imprisonment and/or fines.

I declare that all of the above statements on this claim are true and complete to the best of my knowledge.

I understand that I have the right to revoke this authorization at any time. I understand this must be in writing and addressed to the privacy officer of the above named facility. This authorization will be valid until coverage expires.

_____ _____

Claimant Signature/Legal Representative Date

## SECTION IV – CLAIM PROVISIONS

**Notice of Claim/Disability**

Written notice of any injury or sickness must be given within 20 days of the start of disability or as soon after as reasonably possible. The Notice must be given to Trustmark with information that identifies you as an Insured Employee. A Notice of Disability form is included in this booklet. It may be used to report a claim under this Plan.

**Claim Forms/Proof of Loss**

After notice of claim is received, Trustmark will send you forms for the filing of proofs of loss. You will have met the proof of loss requirement if you and your doctor complete and send back the form Trustmark sends you, or give Trustmark an adequate written statement of the nature and extent of the loss, within ninety (90) days after the start of the Period of Disability for which benefits are claimed under the Plan. However, a claim will still be considered if it was not possible to furnish completed forms or other proof of loss within this 90-day period and the proof was furnished as soon as possible.

The proof must show that you have applied, and have furnished proofs when asked, for all disability benefits.

**Time of Payment of Claims**

Subject to written proof of Total Disability, all accrued benefits will be paid monthly. Any balance that has not been paid by the end of disability will be paid immediately upon receipt of due written proof.

**Payment of Claims**

All benefits will be paid to you, if living, otherwise to your estate. If benefits are payable:

- to your estate; or
- to a person who cannot legally give a valid release;

Trustmark can pay up to $1,000 to someone related to you by blood or marriage who Trustmark believes has a right to it. Neither the Plan nor Trustmark will be held responsible for any such payment made in good faith.

**Investigation and Physical Examination**

Trustmark will have the right to examine you as often as it may reasonably require while a claim is pending. This will be at the expense of Trustmark. If you fail to cooperate with Trustmark's investigation of your claim or Trustmark's request that you submit to an examination,

Trustmark will deny your request for benefits or terminate your benefits, regardless of whether the Plan is prejudiced.

**Response to Claim for Benefits**

Trustmark will respond to your claim for benefits under the Plan within 45 days after it receives your claim. The period for response may be extended twice for periods no longer than 30 days each, if Trustmark notifies you of the need for extension before the date a decision must be made, and if the extension is needed because of matters beyond the control of the Plan. A notice of extension will explain the reason for the extension, the unresolved issues that prevent a decision from being made, and any additional information needed from you to make a decision on your claim. You will have 45 days from the time you receive a request for additional information to provide the information to Trustmark. Trustmark may also periodically evaluate your disability status or whether you otherwise continue to be entitled to Plan benefits. A finding that you are no longer Totally Disabled or otherwise no longer entitled to receive benefits under the Plan would be considered a denied claim for purposes of these claims procedures.

**Appeals from Claim Denials**

If your claim for benefits under the Plan is denied, you will receive an explanation written in a manner that can be understood by you, giving: (i) reasons for the denial; (ii) specific reference to provisions in Group Policy 9000 on which the denial is based; (iii) a description of any additional material or information necessary for you to perfect the claim and an explanation why such additional material or information is necessary; (iv) an explanation of the claims appeal procedures and the time limits associated with those procedures; (v) a copy of any internal rule, guideline, protocol, or similar criteria that Trustmark relied on in denying your claim, or a statement that a copy will be provided at no cost upon your request; and (vi) if your claim is denied because Trustmark determined that you were not receiving care which is appropriate for the nature of your condition (see definition of Totally Disabled on page 6), an explanation of the scientific or clinical judgment for the determination, applying the terms of the Group Policy 9000 to your medical condition, or a statement that such explanation will be provided to you at no charge upon request.

When Trustmark conducts a periodic claim evaluation and determines

that you are no longer entitled to continued benefits, Trustmark will notify you in writing. The notice will contain similar information that is included in a claim denial notice. You have the same appeal rights associated with a denied claim.

If you are not satisfied, or you do not agree with the reasons for the denial of your claim, you may appeal the decision to Trustmark. This appeal must be in writing, and can be made by your or your duly authorized representative. It must set out the reasons for the appeal and your dissatisfaction or disagreement. Any evidence or documentation to support your position should be submitted with your written appeal. Upon written request, you or your duly authorized representative may review the pertinent documents that pertain to your claim and its denial. Your appeal must be made within 180 days of the date of the letter denying the claim.

Trustmark will promptly review the claim and appeal. It will advise you of its decision with specific reference to the Plan provisions on which the decision is based. This written decision will be sent to you not later than 90 days after Trustmark's receipt of your written appeal.

If you are dissatisfied with Trustmark's determination upon your appeal, you or your representative may, within 60 days from the date of the written decision, refer the matter to the appropriate Disputes Committee.

A Disputes Committee made up of a panel of legally qualified physicians will at your request consider any dispute requiring medical judgment that involves:

- your eligibility for benefits under this Plan;
- determination of your physical condition;
- the cause of disability; or
- the date disability started.

The panel of physicians will include one selected by you or your union representative, one selected by your employing railroad, and one selected by Trustmark. In the event this panel is unable to reach a decision, they will select another legally qualified physician for decision. Such decision will be binding on all parties.

Another Disputes Committee will at your request consider any dispute involving application of the terms, conditions and provisions of the Plan between you and/or a participating railroad and/or Trustmark. This Committee will consist of two members appointed by National Carriers' Conference Committee, two members appointed by the labor union representing you, and (if the dispute involves Trustmark) two members

appointed by Trustmark. If this Committee cannot reach a decision, the dispute will be submitted to arbitration.

All expenses in connection with the resolution of disputes will be paid by the person or persons incurring the expenses. Fees and expenses, however, of any physician selected by the panel of physicians or any neutral arbitrator selected by the parties as described above will be divided equally by the parties involved in the dispute. The compensation and expenses of any arbitrators appointed by the National Mediation Board shall be paid in accordance with existing law.

**Legal Actions**

No action can be brought to receive a benefit under the Plan until you have exhausted the appeals process. Furthermore, no action can be brought after 3 years has passed from the deadline for providing Trustmark with written proof of disability that meets the Plan's requirements.

**Choice of Physician**

You will have free choice of any physician practicing legally. Neither the Plan nor Trustmark will in any way disturb the physician-patient relationship.

## SECTION V – ADDITIONAL INFORMATON

**Federal Tax Information**

Federal Law requires that benefit payments under this Plan be reported to the Internal Revenue Service. You will be furnished with a W-2 Form showing the amount of benefits, if any, you are paid each year.

Federal Law also requires that Railroad Retirement Tier I Taxes be withheld from Plan payments made during the first six (6) months following the month of disability. Your employer is required to pay a matching share of the Railroad Retirement Tax withheld.

**Liability Cases**

This Plan has been established and maintained in fulfillment of certain collective bargaining agreements. The agreements contain the following provision:

> "In case of a disability for which the employee may have a right of recovery against either the employing railroad or a third party, or both, benefits will be paid under this Plan pending final resolution of the matter so that the employee will not be exclusively dependent upon his sickness benefits under the Railroad Unemployment Insurance Act. However, the parties hereto do not intend that benefits under this Plan will duplicate, in whole or in part, any amount recovered for loss of wages from either the employing railroad or a third party, and they intend that benefits paid under this Plan will satisfy any right of recovery for loss of wages against the employing railroad to the extent of the benefits so paid. Accordingly, benefits paid under this Plan will be offset against any right of recovery for loss of wages the employee may have against the employing railroad; the insuring agent will be subrogated to any right of recovery for loss of wages the employee may have against any party other than the employing railroad;..."

Thus, if benefits are paid under this Plan, the benefit payments will be deducted from any payment made in any case involving a claim for loss of wages and in which the employer or a third party may be liable for the injury.

**Subrogation**

In the event any benefits are paid to an Insured Employee under the Plan, Trustmark shall be subrogated and succeed to the Insured

Employee's right to receive a payment for loss of wages against any third party, other than the employing railroad. The Insured Employee shall pay over to Trustmark all sums received, by suit, settlement or otherwise, on account of such loss of wages, but not to exceed the amount of benefits paid under the Plan. As a condition to paying any benefits under the Plan, Trustmark may require the Insured Employee to assign to Trustmark any payment or right thereto from any third party other than the employing railroad to the extent that benefits are payable under the Plan.

For purposes of this provision, a payment which does not specify the matters covered by it shall be deemed to include a payment for loss of wages to the extent of any actual wage loss due to the disability involved. The Insured Employee: shall take such action, furnish such information and assistance, and execute such assignments and other instruments, all as Trustmark may require to facilitate enforcement of the rights of Trustmark; and shall take no action prejudicing the rights and interest of Trustmark.

**Recovery of Overpayments**

Trustmark and/or the Plan has the right to recover any overpayments due to fraud, any error made in processing a claim, your receipt of other payments, your eligibility to receive benefits for a disability under any other plan, fund or other arrangement for which an employer has contributed, or any other reason. In the event of an overpayment, you must reimburse Trustmark in full, regardless of whether you have retained the benefits you received and/or the payments you received from another source which gave rise to the overpayment. In any event, Trustmark shall automatically have a first priority lien upon any overpaid benefits and any benefits received from another source that gives rise to the overpayment, up to the amount of the overpayment. If Trustmark notifies you of an overpayment and you fail to reimburse Trustmark for the full amount, Trustmark and/or the Plan may initiate legal action to obtain legal and/or equitable relief to recover the overpayment. If Trustmark and/or the Plan is successful in that legal action, Trustmark and/or the Plan will seek the full relief available to it under the law, including but not limited to recovery of the overpayment, interest, costs, and attorney's fees. If Trustmark determines that the overpayment resulted from fraud, Trustmark and/or the Plan will pursue all appropriate legal remedies. Trustmark may also recover overpayments that you fail to reimburse by withholding all or some benefits that would otherwise be

payable to you under the plan, until such time as the overpayment has been recovered.

**Interpreting Plan Provisions**

Trustmark has discretionary authority to determine whether and to what extent Insured Employees are entitled to benefits that the company insures and to construe all relevant terms, limitations and conditions set forth in this booklet or in any other document or instrument pursuant to which the Plan is established or maintained. Trustmark shall be deemed to have properly exercised this discretionary authority unless the company has acted arbitrarily or capriciously.

# INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT ("ERISA") OF 1974

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The following information and the rest of this booklet form the Summary Plan Description under the Employee Retirement Income Security Act of 1974, sometimes called "ERISA":

- **Name of Plan:**

  Supplemental Sickness Benefit Plan for Railroad Yardmaster Employees

- **Plan Identification Numbers:**

  Employer Identification No. (EIN): 53-1036399

  Plan No.: 507

- **Type of Administration:** Fully Insured Plan

  Trustmark is the insurer. Group Policy 9000 is the insurance policy. In connection with its review of claim determinations, Trustmark has been given the discretion, to be exercised in accordance with the Plan's terms, to construe disputed terms, limitations, and conditions of Group Policy 9000 and of any other document or instrument, including this booklet, under which the Plan is maintained.

- **Plan Administrator:**

  National Carriers' Conference Committee
  1901 L Street, N.W., Suite 500
  Washington, D.C. 20036
  Tel: 202/862-7200

  The Plan Administrator has authority to control and manage the operation and administration of the Plan and is the agent for service of legal process.

- **Date of End of Plan Year:**

  Each plan year ends on December 31.

# INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT ("ERISA") OF 1974

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- **Source of Plan Contributions:**

  Most participating employers pay as premiums the entire cost necessary for their employees to participate in the Plan. For employees of participating railroads that pay the entire cost of the Plan, there are no employee contributions. The cost of coverage for any covered General Chairman or other full-time labor representative will be paid through the labor union with which he or she is affiliated. A small number of participating employers may have collective bargaining agreements that provide for employees to contribute to the cost of the Plan through payroll deductions.

- **Claim Procedures:**

  See SECTION IV – CLAIMS PROCEDURES.

- **Plan Termination:**

  The right is reserved in the Plan for the Plan Administrator to amend or modify the Plan in whole or in part any time.

  A participating railroad or labor union has the right to terminate its participation in the Plan at any time by delivering to the Plan Administrator written notice of such termination, except as such right may be limited by obligations undertaken in collective bargaining agreements.

As a participant in the Plan you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be entitled to the following.

**Receive Information about Your Plan and Benefits**

1. You may examine, without charge, at the Plan Administrator's office and at other locations, such as work sites and union halls, all Plan documents, including Group Policy 9000, the collective bargaining agreements under which the Plan was established and is maintained, and a copy of the latest annual report (Form 5500

series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

2. You may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including Group Policy 9000, the collective bargaining agreements under which the Plan was established and is maintained, copies of the latest annual report (Form 5500 series), and an updated summary plan description. The Administrator may make a reasonable charge for the copies.
3. You are entitled to receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

**Prudent Actions by Plan Fiduciaries**

In addition to creating rights for Plan participants, ERISA imposes duties upon persons who are responsible for the operation of the employee benefit plan.

The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

**Enforce Your Rights**

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and

pay you up to $110.00 a day until you receive the material. This does not apply if the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied in whole or in part, you may pursue the remedies outlined in this booklet and then seek review of any decision by initiating an action in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

**Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

**TRUSTMARK INSURANCE COMPANY**
**TRUSTMARK LIFE INSURANCE COMPANY**
**(We, Us, Our)**

## NOTICE OF PRIVACY PRACTICES

Effective date of this notice: April 1, 2006

### Our Commitment to Protecting Your Privacy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

As you may be aware, recent laws require that We provide you with notice as to how We protect an insured's "*Nonpublic Personal Information*." We want you to know that We are guided by Our respect for the confidentiality of your Personal Information. We are providing you with this notice in accordance with recent laws and because We want you to understand that We value your privacy.

**You do not need to respond to this notice in any way.**

**Information We Collect**

*Personal Information* is any information that We obtained about you in the course of issuing insurance, or providing you with any of Our services. The information We obtain could include but is not limited to:

- Social Security number;
- Medical history;
- Employment history;
- Credit history;
- Income information; or
- Bank or credit card numbers.

This information may have been obtained from several sources including:

- Applications or other forms you complete;
- Your business dealings with Us and other companies; or
- Consumer reporting agencies.

**Our Privacy and Security Procedures**

We protect your Personal Information. The only employees who have access to this information are those who must provide products or services to you. Below are some examples of Our guidelines for protecting information.

- Paper copies, when used, are viewed, discussed, and retained in private surroundings.

- Individuals viewing information stored in a computer must have passwords to gain access. Passwords are provided only to individuals who must have access to provide products or services to Our insureds.
- We have guidelines in place to make sure that our business associates use information only for the purpose provided. Each business associate signs a contract agreeing to follow Our privacy procedures.

**Information We Disclose**

We do not disclose any information about you to anyone, except as allowed by law, including the Fair Credit Reporting Act. We may share all of the information We collect with insurance companies, agents, companies that help Us to conduct Our insurance business, companies that are self-insured, or others as permitted by law. Below are examples of the times We may share information for plan business purposes:

- Underwriting;
- Premium rating;
- Submitting claims;
- Reinsuring risk;
- Assessing quality;
- Business management and planning; and
- Sales, transfer, merger or consolidation of the business.
- It may be shared to assess eligibility for insurance benefits or payment.
- It may be shared to find or prevent criminal activity, fraud, material misrepresentation or material non-disclosures in connection with an insurance issue.
- It may be shared with a medical care institution or professional to verify coverage.
- It may be shared with a medical care institution or professional relating to a medical problem of which the insured may not be aware.
- It may be shared with a medical care institution or professional to conduct an audit of their activities.
- It may be shared for case management activities.
- It may be shared to coordinate care.
- We may share information about drug and disease management approaches and treatment, and related information that is not treatment.
- It may be shared for the collection of premium, the payment of benefits and other claims administration.
- It may be shared with a regulatory authority.
- It may be shared with a law enforcement authority or other government authority as required by law.

- It may be shared as otherwise permitted or required by law.
- It may be shared in response to an administrative or judicial order, including a search warrant or subpoena.
- It may be shared to conduct actuarial or research studies. In this case individuals would not be identified in the research report. Material identifying an individual would be destroyed as soon as it was no longer needed.
- It may be shared with Our business associates for use in auditing services or operations, or auditing marketing services.
- It may be shared with a group policyholder for reporting claims experience, or for conducting an audit of Our operations or services.
- It may be shared to consult with outside health care providers, consultants and attorneys, and other health related services.

We require those with whom We share information to agree to follow Our privacy guidelines. In sharing information, We share only that which is reasonably necessary to accomplish the task. Please note that information that We get from a report made by a company that assists Us to conduct insurance business may be retained by that company and used for other purposes.

Uses and disclosures of Personal Information for purposes other than those described above will be made only with your written authorization. If you provide Us authorization to use or disclose your Personal Information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, We will no longer use or disclose information for the specific purpose contained in the authorization. You understand that We are unable to take back any disclosures already made with your authorization, and that We are required to retain any records We may have containing Your Personal Information. If you revoke your authorization for payment or health care operations, you may jeopardize the administration of the benefits under your health plan.

**Our Privacy Commitment**

We understand the importance of protecting your private information. Our highest priority is to maintain your trust and confidence. We will maintain our commitment to safeguarding the information now and in the future. We are committed to maintaining your privacy and are required by law:

- to maintain the privacy of Personal Information and to provide you with notice of Our legal duties and privacy practices with respect to Personal Information;
- to abide by the terms of the Notice of Privacy Practices currently in effect.

We reserve the right to change the terms of this privacy notice, and have such change be effective for all Personal Information that is maintained. Notification of

a revised privacy notice will be provided through one of the following:

- U.S. Postal Service
- Revised Plan Document
- Internet E-mail.

Upon written request, you have the right to:

- request restrictions on certain uses and disclosures of your Personal Information, although We are not required to agree to a requested restriction
- receive confidential communication of Personal Information
- access Our records containing descriptions of your Personal Information
- request an amendment to your Personal Information, although We are not required to agree to a requested amendment
- receive an accounting of impermissible Personal Information disclosures or disclosures made in compliance with the Rule (or state regulations, if applicable) for which an accounting is required.

The written request must reasonably describe the information. The information requested must be reasonably locatable and retrievable.

**How to File a Complaint Regarding the Use and Disclosure of Personal Information**

If you believe your privacy rights have been violated, you may file a complaint with Us, your respective state insurance department or with the Secretary of Health and Human Services. All complaints must be in writing. Please be assured that you may not be retaliated against for filing a complaint.

**How to Contact Us**

You may contact Our representative at the following address:
Privacy Officer
Privacy Request
Trustmark Companies
PO Box 7961
Lake Forest, IL 60045-7961
Email – PrivacyComplianceDepartment@Trustmarkinsurance.com

Any right a consumer, claimant, or beneficiary may have under this notice is not limited by any other privacy notice used by Us.

# CERTIFICATE OF COVERAGE

**TRUSTMARK INSURANCE COMPANY**
**Lake Forest, Illinois**
(Hereinafter called Trustmark)

Certifies that it has issued Group Policy No. 9000 based on the application made by

**NATIONAL CARRIERS' CONFERENCE COMMITTEE**
**of Washington, D.C.**

acting on behalf of the railroads and other employers participating in the Supplemental Sickness Benefit Plan for Railroad Yardmaster Employees. Such railroads are listed in Exhibit C to Group Policy 9000 and collectively constitute the Policyholder.

This booklet summarizes the principal provisions of the Group Policy as amended effective January 1, 2010. The Group Policy constitutes the entire contract between Trustmark and the Policyholder.

The Group Policy specifies the time when and circumstances under which Trustmark is liable for benefits.

Employees become covered under the Group Policy as provided on the foregoing pages. This booklet becomes the Employee's certificate of coverage while covered under the Group Policy.

The benefits and provisions described on the foregoing pages are subject in all respects to the specific terms and conditions of the Group Policy, which will control in the case of any conflict.

Chief Operating Officer
Trustmark Insurance Company

**TRUSTMARK INSURANCE COMPANY**
P.O.Box 7901
Lake Forest, Illinois 60045

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Hicksville, NY
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INTERNATIONAL BROTHERHOOD OF TEAMSTERS 1966

No. BC-UTU 2010