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? (Month) (Day) (Year) ☐ A.M. ☐ 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 ☐ Leave of Absence ☐ Retired ☐ Other (Explain) ☐ Furlough ☐ Discharged ☐ Resigned

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.

Date of Accident (Month) (Day) (Year) ☐ A.M. ☐ P.M.	Were you working when the accident happened? ☐ Yes ☐ No 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.

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 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 are true and complete to the best of my knowledge and belief

Signature of Employee

Date

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 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

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

IMPAIRMENTS

(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%)
☐ 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