

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		Indicate which Organization represents you: ___ARASA		
Department Last Worked	Location Last Worked	<input type="checkbox"/> Maintenance of Way	<input type="checkbox"/> Electrical Workers	<input type="checkbox"/> Boilermakers, etc.
Date You Last Worked	Next Scheduled Work Day	<input type="checkbox"/> Signalmen	<input type="checkbox"/> Railway Carmen	<input type="checkbox"/> Firemen & Oilers
		<input type="checkbox"/> Machinists & Aerospace	<input type="checkbox"/> Sheet Metal Workers	<input type="checkbox"/> 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.	Indicate Cause of Disability		
1. ()	()	<input type="checkbox"/> Accident (Complete Part II) <input type="checkbox"/> Sickness		
2. ()	()	Have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
3. ()	()	▪ If Yes, provide your return to work date _____		
		▪ If No, when do you expect to return to work? _____		
4. ()	()	Have you received vacation pay since your last day worked? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		▪ If Yes, provide date(s) _____		
Date of First Treatment		Do you hold any of the following certifications? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> DOT <input type="checkbox"/> CRANE <input type="checkbox"/> CDL <input type="checkbox"/> Other _____		
		▪ If Yes, Have you been medically certified to return to work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you completed a total of at least 12 calendar months of employment with one or more participating railroads? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did you work for the Employer named above (or take vacation with pay) in the month before you became disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		

SECTION II TO BE COMPLETED ONLY IF ACCIDENT INVOLVED

Date of Accident	Were you at work when accident happened? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, 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 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? I am not qualified under the Act My benefits have exhausted for this benefit year Other _____

Other Income Benefits:

- 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>**