NOTICE OF DISABILITY FORM – *Supplemental Sickness Benefit Plan*

The Hartford
P.O. BOX 14869
LEXINGTON, KY 40512
PHONE: (800) 205-7651
FAX: (833) 357-5153

THE HARTFORD is the claim administrator for your Railroad Supplemental Sickness Benefit Plan
Within 60 days of your first day absent from work call 1800-205-7651 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 ( )	Hire Date

Name of Employer	Indicate which Organization represents you: ___ARASA
Department Last Worked / Location Last Worked	0 Maintenance of Way 0 Electrical Workers 0 Boilermakers, etc. 0 Other
Date You Last Worked / Next Scheduled Work Day	0 Signalmen 0 Railway Carmen 0 Firemen & Oilers
Rate of Pay (per hr./ per month) $	Occupation
Date You Became Disabled	Supervisor's Name / Telephone No. ( )
Name of All Treating Physicians / Telephone No. 1. ( )	Indicate Cause of Disability 0 Accident (Complete Part II) 0 Sickness
2. ( )	Have you returned to work? 0 Yes 0 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? 0 Yes 0 No provide date(s)
Date of First Treatment	Do you hold any of the following certifications? 0 Yes 0 No 0 DOT 0 CRANE 0 CDL 0 Other • If Yes, Have you been medically certified to return to work 0 Yes 0 No
Have you completed a total of at least 12 calendar months of employment with one or more participating railroads? 0 Yes 0 No	Did you work for the Employer named above (or take vacation with pay) in the month before you became disabled? 0 Yes 0 No

SECTION II TO BE COMPLETED ONLY IF ACCIDENT INVOLVED

Date of accident — Were you at work when the accident happened? 0 Yes 0 No — If yes, for whom?

Explain how accident happened

Was a railroad off-track vehicle involved? 0 Yes 0 No

Did injury result from a traffic accident 0 Yes 0 No

Will a liability claim be made? 0 Yes 0 No

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

Benefits under the Railroad Unemployment Insurance Act:

1. Have you applied for sickness benefits under the Railroad Unemployment Insurance Act? 0 Yes 0 No

If not, why not? 0 I am not qualified under the Act 0 My benefits have exhausted for this benefit year 0 Other

Other Income Benefits:

1. Are any of the "Other Income Benefits" listed below available to you while disabled? (If yes, check each of the following that apply, and show the monthly amounts payable) 0 Yes 0 No

0	Railroad Retirement Act – Disability Annuity	$
0	Social Security Act 0 Because of Age 0 Because of Disability	$
0	Military Pension 0 Because of Years of Service 0 Because of Disability	$
0	Wage Continuation	$
0	Off-Track Vehicle Agreement	$
0	Protective Agreement	$
0	Advancement from possible settlement with Railroad	$
0	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://abilityadvantage.thehartford.com