NOTICE OF DISABILITY

Supplemental Sickness Benefit Plan

CORESOURCE
A Trustmark Company
PERSONAL. FLEXIBLE. TRUSTED.

RAILROAD DISABILITY CLAIMS
Customer Service Telephone Number:
855-760-3132
Fax: 586-439-5998
Email: dfax@coresource.com

ADMINISTRATOR
CoreSource
P.O. Box 7948
Lake Forest, IL 60045

IF YOU BECOME DISABLED, YOU AND YOUR ATTENDING PHYSICIAN(S) SHOULD FULLY COMPLETE ALL PARTS **IMMEDIATELY** AND RETURN TO CORESOURCE.

SECTION I THIS SECTION MUST BE COMPLETED BY OR IN BEHALF OF THE EMPLOYEE FOR ALL CLAIMS.

Name of Employee (Please Print)	Date of Birth	Social Security Number	Employee Number

Employee's Address (Number) (Street) (City) (State) (Zip) ☐ Please indicate if new address	Telephone Number ( )	Date Employed

Name of Employer

Department Last Worked | Location Last Worked

Date You Last Worked | Rate of Pay (per hr./per month) $

Occupation | When Did You Become Disabled? Date Time ☐ AM ☐ PM

Supervisor's Name | Telephone No. ( )

1. Name Of All Treating Physicians | Telephone No. ( )

2. ( )

3. ( )

Date of First Treatment

Have you completed a total of at least 12 calendar months of employment with one or more participating railroads? ☐ Yes ☐ No

Indicate which Organization represents you:
☐ United Transportation Union
☐ Other_____

Indicate Occupation:
☐ 1. Conductor ☐ 4. Other_____
☐ 2. Brakeman
☐ 3. Foreman

Indicate Cause of Disability
☐ Accident (Complete Part II) ☐ Sickness (show cause)

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 your last day worked? ☐ Yes ☐ No
If yes, give date(s)

Do you currently hold a medical certification? ☐ Yes ☐ No
☐ DOT ☐ CRANE ☐ Other

Did you work for the Employer named above (or take vacation with pay) in the month before you became disabled? ☐ Yes ☐ No

SECTION II TO BE COMPLETED ONLY IF ACCIDENT INVOLVED

Date Of Accident

Were you at work when accident happened?
☐ Yes ☐ No If yes, for whom?

Explain How Accident Happened?

Was a railroad off-track vehicle involved?	Did injury result from a traffic accident?	Will a Liability claim be made?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

SECTION III THIS SECTION MUST BE COMPLETED AND SIGNED BY OR IN 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? ☐ Yes ☐ No
2. If not, why not? ☐ Am not qualified under the Act. ☐ 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 yes, check each of the following which is applicable, and show monthly amounts payable).

- ☐ Railroad Retirement Act–Disability Annuity ..... $ _____
- ☐ Social Security Act (Are Benefits for Age or Disability? _____) ..... $ _____
- ☐ Military Pension (Are Benefits for Years of Service or 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) ..... $ _____

SECTION IV ATTENDING PHYSICIAN'S STATEMENT (Please fully complete all questions to expedite claim)

1. Name of Employee

2. Social Security Number

3. Diagnosis and concurrent conditions
(If diagnosis code other than ICD9* used, give name):

4. Dates of Treatment (If previous form submitted to this carrier, you need show only dates since last report) First:	3. Dates of Hospital Confinement Admitted Discharged

5. Has patient had surgery/outpatient procedures? (If so, date _____)

6. Frequency of Treatment

7. Is patient receiving physical therapy? ☐ Yes ☐ No If "Yes" indicate name and address of facility/therapist

8. Date symptoms first appeared or accident happened.

9. Date patient first consulted you for this condition.

10. Patient ever had same or similar condition? ☐ Yes ☐ No If "Yes" when and describe

11. Patient still under your care for this condition? ☐ Yes ☐ No If "No", has patient been referred to another physician?

12. Patient was continuously unable to perform the regular duties of his/her own occupation. From To

13. If patient was released to restricted duty, please indicate all restrictions and applicable dates.

14. If still disabled, date patient should be able to return to work

Date Completed	Physician's Name (Print)	Signature	Degree	Taxpayer's Account No.

Street Address	City or Town	State or Province	Zip Code	Telephone No. / Fax No.

Any 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, in Florida, a felony of the third degree.

The undersigned certifies that the information disclosed above is a correct declaration of facts upon which claim is based for benefits and further hereby acknowledges the limitations and provisions of the plan.

AUTHORIZATION

Solely to assist CoreSource in administering an insurance claim. I hereby authorize any provider of health care including but not limited to any institution, or person possessing information concerning:

_____

to permit the above named insurance company and its representative, insurance support organization, reinsurance companies or other persons performing business or legal services in connection with the claim, to view, copy, be furnished copies or be given details of all such physical or mental medical–record information including but not limited to drug, alcohol or psychiatric treatment or condition, as well as information regarding employment income, other insurance coverage, and/or any otherwise personal or privileged information, including but not limited to any other claim for insurance benefits, or any records concerning civil or criminal proceedings.

Any copy of the authorization shall have the same authority as the original.

I understand I, or my authorized representative, may receive a copy of this authorization upon request. This authorization is valid for the duration of the claim.

Signature _____ Date _____