SICKNESS LEAVES

2022 March Training Seminar
Omaha, NE

AGENDA

Sickness Leaves

- RRB Benefits
- Hartford Benefits
- Aflac Benefits

COVID Leaves

- Exceptions and Differences from regular Sickness Leaves

Leaves Admin

- BNSF Policies
- General Best Practices

Contacting RRB

- Phone
- Email/Secure Messaging

RRB Benefits: Process Overview

- Placed on Medical Leave
  - Sickness, Surgery, Medical Disqualification, Injury, Rehabilitation, Long-term COVID
- Apply for RRB Benefits
  - Fill out the 3 forms
  - Submit the forms
- Waiting Period
  - 7 calendar days from the first day of your leave
- Receiving Benefits
  - 4-6 week turnaround time
  - Biweekly SI-3

RRB Forms:

Application of Sickness Benefits

- Pages 1-2
  - Standard Application Questions
- Page 3
  - Statement of Sickness
  - Doctor's portion
- Pages 4-5
  - Statement of Authority to Act for Employee
  - Only needed when member cannot sign for themselves

United States of America
Railroad Retirement Board

Form Approved
OMB No. 3220-0039

Application for Sickness Benefits

Section A **Identifying Information**

1. Employee's Name (First, Middle Initial, and Last)
2. Social Security Number — –
3. Employee's Street Address, City, State and ZIP Code (Including Apartment Number)
4. Date of Birth: Month / Day / Year
5. Sex: ❑ Male ❑ Female
6. Telephone Number (Include Area Code) ( )

Section B **Infirmity and Employment Information**

7. Date You Became Sick or Injured ____
8. Date You Last Worked for a Railroad ____
9. Last Railroad Employer (Name of Company) ____
10. Location of Last Railroad Employment (City/State) ____
11. Last Railroad Occupation ____
12. Department ____
13. If you worked for a nonrailroad employer after the date shown in Item 8, complete Items A, B, and C, below. Otherwise, **go to Item 14.**
    A. Last Nonrailroad Employer (Name of Company) ____
    B. Last Occupation After Railroad Work ____
    C. Date Last Worked After Railroad Work ____

Section C **Accident and Insurance Information**

14. Are you applying for sickness benefits because you were injured at work or have a work-related illness? ❑ Yes ❑ No
15. Have you filed or do you expect to file a lawsuit or claim against any person or company for personal injury?
    ❑ Yes - **Complete Items A-D, below** ❑ No - **Go to Item 16**
    A. Furnish the name and complete address of the person or company.
    Name ____
    Address ____
    City, State, ZIP Code ____
    B. Give the place where the injury occurred. ____
    C. Were you injured in an automobile accident? ❑ Yes ❑ No - **Go to Item 16**
    D. If you were injured in an automobile accident, provide information about all the vehicles, ***other than your own,*** that were involved in the accident that caused your injury. Information about your vehicle and insurance company is not needed. If you need more space attach a separate sheet of paper.

Owner of Car (other vehicle)	**Driver (other vehicle)**
Name	Name
Address	Address
City, State, ZIP Code	City, State, ZIP Code
Insurance Company (other vehicle)	**Policy Information (other vehicle)**
Name	Policy Number
Address	Claim Number
City, State, ZIP Code	

Continued on Next Page

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Section D Claim for Sickness Benefits Information

16. Enter the earliest date you wish to claim sickness benefits. ____

17. Are you claiming all the days of sickness beginning with the date you entered in Item 16? (**Note:** You may claim rest days if you were unable to work and did not receive pay from your employer.) ☐ Yes - **Go to Item 19** ☐ No - **Go to Item 18**

18. Enter any dates that you do not wish to claim. ____

19. Enter the date you returned to work (if applicable). ____

20. **You must complete all boxes** to indicate if you have received or will receive any of the following payments for your days of sickness. If you check "YES" for any item, be sure to provide the requested information.

A. WAGES (Include Railroad and Nonrailroad Wages)

YES	NO	If "YES," show the dates for which you were paid in Month/Day/Year format below.
☐	☐	Regular Wages. ____
☐	☐	Vacation Pay ____
☐	☐	Holiday Pay ____
☐	☐	Military Reservist Pay ____
☐	☐	Wage Continuation Pay ____
☐	☐	Earnings from Self-Employment ____
☐	☐	Sick Pay from Your Employer ____ (but not payments supplementing Railroad Retirement Board (RRB) benefits. See Booklet UB-11)

B. GOVERNMENTAL PAYMENTS (Not RRB Sickness Benefits)

YES	NO	If "YES," enclose copy of award letter and complete Items 1 - 3 below.
☐	☐	Sickness or Unemployment Benefits Under Any Other Law
☐	☐	Social Security Benefits
☐	☐	Railroad Retirement or Disability Annuity
☐	☐	Military Retirement Pay
☐	☐	Worker's Compensation
☐	☐	Retirement Payments Under Another Law

1. Beginning Date of Payment ____
2. Gross Amount of Payment $ ____
3. How often do you receive the payment? ☐ Weekly ☐ Monthly ☐ Yearly ☐ Other: ____

C. OTHER PAYMENTS

YES	NO	If "YES," complete Items 1 and 2.
☐	☐	Settlement, Judgment or Damages for Personal Injury
☐	☐	Advances
☐	☐	Separation Allowance (Buyout, Severance Pay)

1. Date of Payment ____
2. Paid By: ____

21. If the date you are submitting this form is **more than 30 days** after the date you entered in Item 16, answer the following:
A. Why did it take more than 30 days to submit this form? If more space is needed, attach a separate sheet of paper. ____
B. How did you obtain this form? ____
C. Who provided this form to you? ____
D. On what date did you obtain the form? ____
E. Furnish the name and title of any person from whom you asked for help in completing and filing the forms.
NAME ____ TITLE ____

Section E Direct Deposit Information

22. Benefits are normally paid by Direct Deposit to your bank, savings and loan, credit union, or other financial institution. To provide the information we need to correctly deposit your payments, **attach a voided personal check and go to Item 23**, or call your financial institution for the information you need to complete Items A-E.

A. Routing Transit Number ☐☐☐☐☐☐☐☐☐ B. Account No. ____
C. Account Type: ☐ Checking ☐ Saving
D. Name of Financial Institution: ____
E. Telephone No. (Include Area Code) (____) ____

Section F Certification and Signature

23. I waive any "doctor-patient privilege" I may have with respect to the disclosure of information concerning the period of sickness or injury on which my claim is based. I certify that I understand and agree to the requirements in Booklet UB-11. I know that disqualification and civil and criminal penalties may be imposed on me for false or fraudulent statements or claims or for withholding information to get benefits from the RRB. I affirm that the information given on this form is true, correct and complete. **NOTE:** If the sick or injured employee is unable to sign this form, sign your name and complete Section 1 of the attached Form SI-10, Statement of Authority to Act for Employee.

SIGNATURE ____ **DATE** ____

SI-1a (03-12) HAVE YOUR DOCTOR COMPLETE THE ATTACHED STATEMENT OF SICKNESS

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Application of Sickness Benefits

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United States of America
Railroad Retirement Board

Form Approved
OMB No. 3220-0039

Statement of Sickness

***Instructions:** This form is to be executed by (1) a doctor trained in medical, surgical, dental or psychological diagnosis of the infirmity described, (2) a certified nurse/midwife in cases of pregnancy or childbirth, (3) a supervisory official of a hospital or similar institution, (4) a chiropractor, (5) a Physician Assistant - Certified, or (6) a nurse practitioner. This form should be completed and returned to the patient immediately for prompt mailing; otherwise he/she may lose benefits. Supplementary medical information may be attached or furnished directly to the Railroad Retirement Board (RRB) at the address shown below. If such information is furnished, please include the patient's social security number and name on the report. Please complete section 2 on the reverse side if patient is incapable of signing forms.*

The RRB is not liable for any charge in connection with completing this form.

1. Patient's Name (First, Middle, and Last)

2. Patient's Social Security Number

3. Have you examined or treated the patient for his or her injury or illness? ❑ Yes ❑ No – **Go to Item 9**

a. Date patient became sick or injured

b. List all dates of examination and treatment for this infirmity

c. Probable date of next examination

4. Diagnosis and concurrent conditions

5. Does the patient's condition require surgery? ❑ Yes ❑ No – **Go to Item 6**

a. Date on which surgery was or will be performed

b. Surgical procedure that was or will be performed

6. Does the patient's condition require hospitalization?

❑ Yes – Enter the period of hospital confinement: From ______________________ To ______________________

❑ No

7. If patient is not working because of maternity or childbirth, complete 7a and 7b.

a. Date patient became unable to work ▶

b. Estimated or actual date of delivery ▶

8. Give the date you believe the patient became or will become able to resume work in his or her occupation. (If indefinite or unknown, please give an estimated date.) ▶

9. I certify that the information I am giving is true, complete, and correct. I understand that criminal and civil penalties may be imposed on me for false or fraudulent statements or for withholding information to cause or prevent payment of benefits by the RRB.

Please print or type:

Name of Doctor	Signature of Doctor	Degree/Title
Address	Office Telephone Number (Include Area Code) ( )	Date
	National Provider Identifier	

PAPERWORK REDUCTION ACT NOTICE TO DOCTOR

Medical evidence is needed to support the payment of claims for sickness benefits under the Railroad Unemployment Insurance Act (RUIA). The RRB is authorized to collect this information under section 12(i) of the RUIA. You are not required to furnish this information. If you do not, however, no benefits can be paid to your patient. We estimate this form and the form on the back of this page take an average of 8 and 6 minutes to complete, respectively. The estimates include the time for reviewing the instructions, getting the needed data, and reviewing the completed forms. Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number. If you wish, send comments regarding the accuracy of our estimate or any other aspect of this form, including suggestions for reducing completion time, to the Chief of Information Resources Management, Railroad Retirement Board, 844 N Rush Street, Chicago, Illinois, 60611-2092. Send completed forms to:

U.S. RAILROAD RETIREMENT BOARD
OFFICE OF PROGRAMS—OPERATIONS
POST OFFICE BOX 10695
CHICAGO, ILLINOIS 60610-0695

Doctor: See Next Page

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  - Only needed when member cannot sign for themselves

United States of America
Railroad Retirement Board

Form Approved
OMB No. 3220-0034

Statement of Authority to Act for Employee

Employee ____________________

Social Security Number____________________

This statement is to be completed when applying for sickness benefits under the Railroad Unemployment Insurance Act (RUIA) on behalf of an employee who is incapable of signing documents and transacting business in connection with his or her benefit payments. The Railroad Retirement Board's (RRB) authority for obtaining this information is section 5(b) of the RUIA. **It is not necessary to file this statement for an employee who can sign papers by mark and understand the transactions.** In such a case, the application should be filled out for the employee, signed by the employee by mark, and the mark witnessed by two persons who should give their full addresses.

Although you are not required to provide information requested on this form, if you fail to do so, the RRB cannot grant authorization to you to act on behalf of the employee.

We estimate this form takes an average of 6 minutes to complete (4 minutes for the applicant and 2 minutes for the doctor), including the time for reviewing the instructions, obtaining the needed data, and reviewing the completed form. Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number. If you wish, send comments regarding the accuracy of our estimate or any other aspect of this form, including suggestions for reducing completion time, to: Associate Chief Information Officer for Policy and Compliance, Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois 60611-1275.

Please read the instructions on the *next page* concerning the completion and return of this form to the Railroad Retirement Board.

Form SI-10 (05-17)

RRB Forms:

Application of Sickness Benefits

- Pages 1-2
  - Standard Application Questions
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United States of America
Railroad Retirement Board

Form Approved
OMB No. 3220-0034

Statement Of Authority To Act For Employee

It is not necessary to complete this form for an employee who can sign papers or can sign by mark and understands transactions relating to his or her sickness benefits.

Instructions

1. Complete Section 1 and have the employee's medical doctor complete Section 2. If you are not related to the employee by blood or marriage, state your relationship and explain why no relative is acting for the employee. For example, an employee's union representative might explain: "I am his union chairman. He has no immediate family."
2. Complete this statement by following the instructions in the UB-11 booklet under "Instructions for Completing Forms, Statement of Authority to Act for Employee (SI-10)." Signing this statement gives you the authority to sign any claim forms on behalf of the employee. When signing claim forms use your full name, and beneath your signature, write "On behalf of" and the employee's full name.
3. Return this form with the next application or claim form you file with the RRB.

Section 1 Statement of Individual Acting for Employee

It is my belief that ____________ (Employee's Name) ____________ (Social Security Number)

whose address is ____________ (Employee's Address)

is at this time incapable of signing forms in connection with obtaining sickness benefits under the Railroad Unemployment Insurance Act; of transacting the necessary business relative to his or her application and claims for such benefits; and of applying the proceeds of any sickness benefit payments.

I believe the employee to be incapable because ____________

(Briefly describe employee's condition)

My relationship to the employee is ____________

I affirm that, in the transaction of business relating to the application and claims of this employee, including the use of any benefit payments, I will act on behalf of and in the best interest of the employee. I will promptly notify the RRB at such time as this employee's condition changes so that I need no longer act for him or her. I understand that criminal and civil penalties may be imposed on me for providing false, incomplete, or fraudulent statements; using the benefits received on something other than the claimant; or for withholding information to cause the payment of benefits. I certify that, to the best of my knowledge, the information I have provided is true, complete, and correct.

Name (please print)	Signature			Phone Number ( )
Street Address (please print)	City	State	ZIP Code	Date

Section 2 Statement of Employee's Doctor

I have examined the employee named above and find that he/she is incapable of signing forms and transacting business relative to his/her claims for sickness benefits under the Railroad Unemployment Insurance Act.

Name of Doctor (please print)		Signature of Doctor		
Office Street Address (please print)	City	State	ZIP Code	Date
National Provider Identifier				

Form SI-10 (05-17)

RRB Forms:

Statement of Claimant

- Page 1
  - Record your statement
- Page 2
  - Optional extra writing space

UNITED STATES OF AMERICA
RAILROAD RETIREMENT BOARD

FORM APPROVED
OMB NO. 3220-0183

STATEMENT OF CLAIMANT OR OTHER PERSON

NAME OF RAILROAD EMPLOYEE	SOCIAL SECURITY NUMBER OF RAILROAD EMPLOYEE
NAME OF CLAIMANT (If other than railroad employee)	RR RETIREMENT ANNUITY CLAIM NUMBER (If different from SS Number)
RELATIONSHIP TO CLAIMANT OF PERSON MAKING STATEMENT	NAME OF PERSON MAKING STATEMENT (If other than claimant)

PLEASE READ THE "IMPORTANT NOTICES" ON THE NEXT PAGE

Understanding that this statement is for the use of the Railroad Retirement Board (RRB), I hereby certify that:

(☐) **If additional space is needed, mark an "X" and continue on the next page.**

CERTIFICATION

I understand that civil and criminal penalties may be imposed on me for false or fraudulent statements, or for withholding information to cause or prevent payment of benefits by the RRB. I affirm that to the best of my knowledge, the information I have given is true, complete, and correct.

SIGNATURE OF PERSON MAKING STATEMENT (First Name, Middle Initial, Last Name) (Write in Ink) **SIGN HERE**	DATE (Month, Day, Year) TELEPHONE NUMBER (Include Area Code)

MAILING ADDRESS (Number and Street, Apt., No., P.O. Box, Rural Route)

CITY, STATE, AND ZIP CODE

If this statement is signed by mark "X," two witnesses who know the person signing must sign below, giving their full addresses.

1. SIGNATURE OF WITNESS	2. SIGNATURE OF WITNESS
ADDRESS (Number and Street, City, State, and ZIP Code)	ADDRESS (Number and Street, City, State, and ZIP Code)

(continued)

RRB Forms:

Statement of Claimant

- Page 1
  - Record your statement
- Page 2
  - Optional extra writing space

IMPORTANT NOTICES

Paperwork Reduction Act and Privacy Act Notices

The Railroad Retirement Board (RRB) is authorized to collect the information requested on this form under Section 7(b)(6) of the Railroad Retirement Act (RRA) and Section 5(b) of the Railroad Unemployment Insurance Act (RUIA). The information will be used to determine entitlement to benefits under these Acts. You are not required to provide this information. However, your failure to do so may result in the loss of benefits for which an application has been filed.

The information you provide on this form may be disclosed without your approval to any individual or institution you identified on this form. Such information may also be disclosed without your approval to the Government Accountability Office for audits, to the Justice Department for collecting overpayments owed to the RRB or the Social Security Administration or for use in criminal and civil proceedings relating to this claim for benefits, to other law enforcement agencies engaged in functions related to the RRA or RUIA, and in administrative hearings or court proceedings relating to a claim for benefits under the Acts.

A complete listing of persons, organizations, and agencies to which the information you give us may be released is available at any office of the RRB, if you wish to see it.

We estimate this form takes an average of 15 minutes per response to complete, including the time for reviewing the instructions, getting the needed data, and reviewing the completed form. Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number. If you wish, send comments regarding the accuracy of our estimate or any other aspect of this form, including suggestions for reducing completion time, to: Associate Chief Information Officer for Policy and Compliance, Railroad Retirement Board, 844 N Rush St., Chicago, IL 60611-1275.

RRB Forms:

Direct Deposit Sign-Up

- Page 1
  - Government Agency Copy
- Pages 2-3
  - Financial Institution Copy
  - Payee Copy
- Page 4
  - Instructions/General Disclaimers

Standard Form 1199A (EG)
(Rev. August 2012)
Prescribed by Treasury Department
Treasury Dept. Cir. 1076

OMB No. 1510-0007

DIRECT DEPOSIT SIGN-UP FORM

DIRECTIONS

- To sign up for Direct Deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 *(TO BE COMPLETED BY PAYEE)*

A NAME OF PAYEE *(last, first, middle initial)*

ADDRESS *(street, route, P.O. Box, APO/FPO)*

CITY STATE ZIP CODE

TELEPHONE NUMBER
AREA CODE

B NAME OF PERSON(S) ENTITLED TO PAYMENT

C CLAIM OR PAYROLL ID NUMBER
Prefix Suffix

D TYPE OF DEPOSITOR ACCOUNT ☐ CHECKING ☐ SAVINGS

E DEPOSITOR ACCOUNT NUMBER

F TYPE OF PAYMENT *(Check only one)*
☐ Social Security
☐ Supplemental Security Income
☐ Railroad Retirement
☐ Civil Service Retirement (OPM)
☐ VA Compensation or Pension
☐ Fed. Salary/Mil. Civilian Pay
☐ Mil. Active
☐ Mil. Retire.
☐ Mil. Survivor
☐ Other ________ *(specify)*

G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY *(if applicable)*
TYPE AMOUNT

PAYEE/JOINT PAYEE CERTIFICATION

I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.

SIGNATURE DATE
SIGNATURE DATE

JOINT ACCOUNT HOLDERS' CERTIFICATION *(optional)*

I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.

SIGNATURE DATE
SIGNATURE DATE

SECTION 2 *(TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)*

GOVERNMENT AGENCY NAME
GOVERNMENT AGENCY ADDRESS

SECTION 3 *(TO BE COMPLETED BY FINANCIAL INSTITUTION)*

NAME AND ADDRESS OF FINANCIAL INSTITUTION
ROUTING NUMBER
CHECK DIGIT
DEPOSITOR ACCOUNT TITLE

FINANCIAL INSTITUTION CERTIFICATION

I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.

PRINT OR TYPE REPRESENTATIVE'S NAME | SIGNATURE OF REPRESENTATIVE | TELEPHONE NUMBER | DATE

Financial institutions should refer to the GREEN BOOK for further instructions.
THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

Reset

NSN 7540-01-058-0224
GOVERNMENT AGENCY COPY
1199-207
Designed using Perform Pro, WHS/DIOR, Mar 97

RRB Forms:

Direct Deposit Sign-Up

- Page 1
  - Government Agency Copy
- Pages 2-3
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  - Payee Copy
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  - Instructions/General Disclaimers

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- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 *(TO BE COMPLETED BY PAYEE)*

A NAME OF PAYEE *(last, first, middle initial)*

ADDRESS *(street, route, P.O. Box, APO/FPO)*

CITY STATE ZIP CODE

TELEPHONE NUMBER
AREA CODE

B NAME OF PERSON(S) ENTITLED TO PAYMENT

C CLAIM OR PAYROLL ID NUMBER
Prefix Suffix

D TYPE OF DEPOSITOR ACCOUNT ☐ CHECKING ☐ SAVINGS

E DEPOSITOR ACCOUNT NUMBER

F TYPE OF PAYMENT *(Check only one)*

- ☐ Social Security
- ☐ Supplemental Security Income
- ☐ Railroad Retirement
- ☐ Civil Service Retirement (OPM)
- ☐ VA Compensation or Pension
- ☐ Fed. Salary/Mil. Civilian Pay
- ☐ Mil. Active
- ☐ Mil. Retire.
- ☐ Mil. Survivor
- ☐ Other *(specify)*

G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY *(if applicable)*
TYPE AMOUNT

PAYEE/JOINT PAYEE CERTIFICATION

I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.

JOINT ACCOUNT HOLDERS' CERTIFICATION *(optional)*

I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.

SIGNATURE	DATE	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

SECTION 2 *(TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)*

GOVERNMENT AGENCY NAME

GOVERNMENT AGENCY ADDRESS

SECTION 3 *(TO BE COMPLETED BY FINANCIAL INSTITUTION)*

NAME AND ADDRESS OF FINANCIAL INSTITUTION

ROUTING NUMBER CHECK DIGIT

DEPOSITOR ACCOUNT TITLE

FINANCIAL INSTITUTION CERTIFICATION

I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.

PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER	DATE

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THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

Reset

NSN 7540-01-058-0224

FINANCIAL INSTITUTION COPY

1199-207
Designed using Perform Pro, WHS/DIOR, Mar 97

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- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 *(TO BE COMPLETED BY PAYEE)*

A NAME OF PAYEE *(last, first, middle initial)*

ADDRESS *(street, route, P.O. Box, APO/FPO)*

CITY | STATE | ZIP CODE

TELEPHONE NUMBER
AREA CODE

B NAME OF PERSON(S) ENTITLED TO PAYMENT

C CLAIM OR PAYROLL ID NUMBER
Prefix | Suffix

D TYPE OF DEPOSITOR ACCOUNT ☐ CHECKING ☐ SAVINGS

E DEPOSITOR ACCOUNT NUMBER

F TYPE OF PAYMENT *(Check only one)*

- ☐ Social Security
- ☐ Supplemental Security Income
- ☐ Railroad Retirement
- ☐ Civil Service Retirement (OPM)
- ☐ VA Compensation or Pension
- ☐ Fed. Salary/Mil. Civilian Pay
- ☐ Mil. Active ____
- ☐ Mil. Retire. ____
- ☐ Mil. Survivor ____
- ☐ Other ____ *(specify)*

G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY *(if applicable)*

TYPE	AMOUNT

PAYEE/JOINT PAYEE CERTIFICATION

I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.

SIGNATURE	DATE
SIGNATURE	DATE

JOINT ACCOUNT HOLDERS' CERTIFICATION *(optional)*

I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.

SIGNATURE	DATE
SIGNATURE	DATE

SECTION 2 *(TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)*

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS

SECTION 3 *(TO BE COMPLETED BY FINANCIAL INSTITUTION)*

NAME AND ADDRESS OF FINANCIAL INSTITUTION

ROUTING NUMBER | CHECK DIGIT

DEPOSITOR ACCOUNT TITLE

FINANCIAL INSTITUTION CERTIFICATION

I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.

PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER	DATE

Financial institutions should refer to the GREEN BOOK for further instructions.
THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

Reset

NSN 7540-01-058-0224

PAYEE COPY

1199-207

Designed using Perform Pro, WHS/DIOR, Mar 97

RRB Forms:

Direct Deposit Sign-Up

- Page 1
  - Government Agency Copy
- Pages 2-3
  - Financial Institution Copy
  - Payee Copy
- Page 4
  - Instructions/General Disclaimers

SF 1199A (Back)

BURDEN ESTIMATE STATEMENT

The estimated average burden associated with this collection of information is 10 minutes per respondent or recordkeeper, depending on individual circumstances. Comments concerning the accuracy of this burden estimate and suggestions for reducing this burden should be directed to the Financial Management Service, Records Management Branch, Room 135, 3700 East-West Highway, Hyattsville, MD 20782. THIS ADDRESS SHOULD ONLY BE USED FOR COMMENTS AND/OR SUGGESTIONS CONCERNING THE AMOUNT OF TIME SPENT TO COLLECT THIS DATA. DO NOT SEND THE COMPLETED PAPERWORK TO THE ADDRESS ABOVE FOR PROCESSING.

PRIVACY ACT NOTICE

Collection of the information in this Direct Deposit Sign-Up form is authorized by 5 U.S.C. § 552a, 31 U.S.C. § 3332(g), and Executive Order 9397 (November 22, 1943). Your social security number and the other information requested will allow the federal government to process your direct deposit. Your social security number is requested to ensure the accurate identification and retention of records pertaining to you and to distinguish you from other recipients of federal payments. This information will be disclosed to the Department of the Treasury and its fiscal and financial agents, and other federal agencies, as necessary to process your direct deposit. This information may also be disclosed to a court, congressional committee or another government agency as authorized or required to verify your receipt of federal payments. Although providing the requested information is voluntary, your direct deposit cannot be processed without it.

PLEASE READ THIS CAREFULLY

All information on this form, including the individual claim number, is required under 31 USC 3322, 31 CFR 209 and/or 210. The information is confidential and is needed to prove entitlement to payments. The information will be used to process payment data from the Federal agency to the financial institution and/or its agent. Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the Direct Deposit/Electronic Funds Transfer Program.

INFORMATION FOUND ON CHECKS

Most of the information needed to complete boxes A and F in Section 1 is printed on your government check:

Ⓐ Be sure that payee's name is written exactly as it appears on the check. Be sure current address is shown.

Ⓕ Type of payment is printed to the left of the amount.

United States Treasury 15-51 / 000
KANSAS CITY, MO
Month Day Year: 08 31 84
Check No. 0000 415785
28 28
DOLLARS CTS
VA COMP Ⓕ
$****100 00
Pay to the order of
JOHN DOE
123 BRISTOL STREET
HAWKINS BRANCH TX 76543
Ⓐ
NOT NEGOTIABLE
':00000518': 041571926"

SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS

Joint account holders should immediately advise both the Government agency and the financial institution of the death of a beneficiary. Funds deposited after the date of death or ineligibility, except for salary payments, are to be returned to the Government agency. The Government agency will then make a determination regarding survivor rights, calculate survivor benefit payments, if any, and begin payments.

CANCELLATION

The agreement represented by this authorization remains in effect until cancelled by the recipient by notice to the Federal agency or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so.

The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately advise the Federal agency if the authorization is cancelled by the financial institution. The financial institution cannot cancel the authorization by advice to the Government agency.

CHANGING RECEIVING FINANCIAL INSTITUTIONS

The payee's Direct Deposit will continue to be received by the selected financial institution until the Government agency is notified by the payee that the payee wishes to change the financial institution receiving the Direct Deposit. To effect this change, the payee will complete a new SF 1199A at the newly selected financial institution. It is recommended that the payee maintain accounts at both financial institutions until the transition is complete, i.e. after the new financial institution receives the payee's Direct Deposit payment.

FALSE STATEMENTS OR FRAUDULENT CLAIMS

Federal law provides a fine of not more than $10,000 or imprisonment for not more than five (5) years or both for presenting a false statement or making a fraudulent claim.

RRB Benefits: Submitting Forms

Ways to Submit Forms

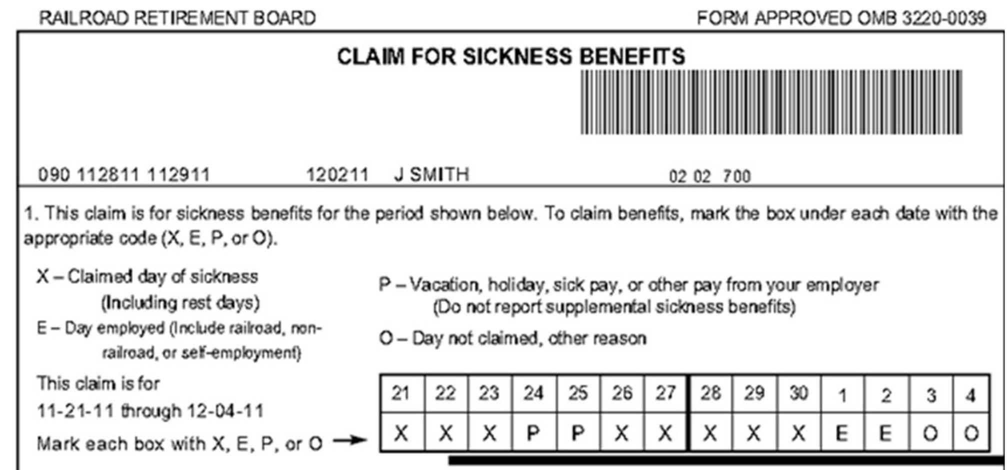
- Fax
  - (312) 751-7185
  - Preferred Method
- Mail
  - US Railroad Retirement Board
    Office of Programs – Operations
    PO Box 10695
    Chicago, Illinois 60610-0695

When to Submit Forms

- Within 30 days of the leave start date
  - Ideally, as soon as possible
- 30+ days after the leave start date
  - Provide explanation for why you waited
- **Never** before your leave start date
  - It will be automatically denied, and you will have to fill it out and submit again.

Claiming Sickness Benefits

- **SI-3 Form-** required biweekly income disclosure form
  - **Section 1**
    - Indicate which days you are claiming
  - **Section 2**
    - Indicate whether you've returned to work
  - **Section 3**
    - Pre-filled the RRB's mailing address
  - **Section 4**
    - Pre-filled with your address, if corrections are needed provide them in the box
  - **Section 5**
    - Tax liability information
  - **Section 6**
    - Sign and date



RAILROAD RETIREMENT BOARD — FORM APPROVED OMB 3220-0039

CLAIM FOR SICKNESS BENEFITS

090 112811 112911 120211 J SMITH 02 02 700

1. This claim is for sickness benefits for the period shown below. To claim benefits, mark the box under each date with the appropriate code (X, E, P, or O).

X – Claimed day of sickness (Including rest days)
E – Day employed (Include railroad, non-railroad, or self-employment)
P – Vacation, holiday, sick pay, or other pay from your employer (Do not report supplemental sickness benefits)
O – Day not claimed, other reason

This claim is for 11-21-11 through 12-04-11
Mark each box with X, E, P, or O →

21	22	23	24	25	26	27	28	29	30	1	2	3	4
X	X	X	P	P	X	X	X	X	X	E	E	O	O

RRB will automatically mail this to you every other week for you to fill out and return, unless you choose to file you SI-3 forms electronically.

Claiming Sickness Benefits Online

Disclaimers

- RRB.gov **does not** allow you to apply for sickness benefits online.
  - You can ***claim*** sickness benefits online by completing an electronic SI-3.
  - Once you fill out one online SI-3
    - You will no longer receive a mailed SI-3, and every subsequent SI-3 must be submitted electronically.
      - To request to change back to paper forms, call or email your local field office.
- Must have a myRRB account set up.

Creating a myRRB Account

- Go to rrb.gov
- Locate and select "My RRB"
  - Select "Create an account"
  - Follow the prompts to create an account
  - Required Information
    - Current, state issued ID
    - Email Address
    - Enabling two step verification
    - Social Security Number
    - Physical Address Verification

Sickness Benefits: The Hartford

- Contact Information
  - Phone: 1-800-205-7651
- Start your claim over the phone and then they will provide specific forms for you to follow up with
  - Medical Authorization Form (2 pages)
  - Supplemental Sickness Claim Form
- Processing & Payout Time
  - Quicker processing than RRB
  - Payout time is dependent on RRB

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I allow all doctors, hospitals, other health care providers, pharmacy, pharmacy benefit managers, government agencies (including, but not limited to, Federal, State or Local , and the Social Security Administration and Veterans Administration), insurers, employers, financial institutions, educational institutions, health plans, health insurance carriers, policyholders, contract holders, vendors, health and benefit insurers and administrators or their successors ("Records Holders") to give to and discuss with The Hartford and its representatives, the following personal, private, or privileged information, records, or documents related to:

Insured's Name (Please Print)	Date of Birth	Employer/Policyholder's Name:

Any and all medical information or records, including medical histories, physical, mental, or diagnostic examinations, pharmaceutical records, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health; work and performance information and history, including job duties and earnings; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; financial information, including pension benefits and bank records; business transaction billing and payment records; academic transcripts; and any and all information concerning Social Security or other government benefits, including monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used by The Hartford (including subsidiaries and affiliates) for the purpose of evaluating and administering my claim(s) for benefits and /or leave request(s) and/or request(s) for accommodation. Such information shall be referred to herein collectively as "My Information."

I understand that once My Information has been disclosed to The Hartford as permitted under this Authorization, it may be re-disclosed by The Hartford as permitted by law or my further authorization. Without limiting the foregoing, I authorize The Hartford to use or disclose My Information (i) to my employer for: a) functions related to accommodating my restrictions/limitations, including in accordance with law; b) responding to claims related to accommodation, adverse or discriminatory treatment related to my claim or condition; c) responding to complaints by me or my representative relating to benefits, leave or accommodation; d) responding to any litigation, agency or regulatory proceeding, or lawful subpoena (including regarding employment claims); e) federal, state, or other leave administration; f) fulfilling fiduciary obligations under my benefit plan; or (g) claim, other audits or benefit program reviews; (ii) to administrators or other service providers, including health and wellness vendors, of my employer's benefit plan(s) and/or programs, including leave management, for plan, benefit, or program related functions or data aggregation and analysis; (iii) to any electronic claim systems or programs or third party vendors used for claims administration or processing or to any insurance broker to carry out functions related to my benefit plan/program or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business, medical, or legal services related to my claim; (vi) for other insurance, reinsurance or analytical purposes, including workers' compensation insurance, Social Security Disability insurance, or subrogation or reimbursement purposes ; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others or myself; (ix) as may be reasonably necessary to respond to regulatory or similar complaints; and (x) as may be reasonably necessary to prevent or detect perpetration of a fraud (all entities and individuals listed in this paragraph including The Hartford defined as "Benefits Manager(s)"). *I understand that My Information disclosed to Benefits Managers and re disclosed could include HIV/AIDS, other communicable diseases and mental health records.*

I understand that My Information disclosed to Benefits Managers pertaining to certain alcohol or drug abuse treatment is protected by federal (42 CFR Part 2) and state confidentiality rules and statutes, which prohibit any further disclosure of this information without my express written consent, or as otherwise permitted by such rules and statutes. I understand that a general authorization for the release of medical or other information is NOT sufficient for release of certain types of alcohol or drug abuse treatment records.

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including underwriting companies Hartford Life and Accident Insurance Company and Hartford Fire Insurance Company. Home Office is Hartford, CT. The Hartford is the administrator for certain group benefits business written by Aetna Life Insurance Company and Talcott Resolution Life Insurance Company (formerly known as Hartford Life Insurance Company). The Hartford also provides administrative and claim services for employer leave of absence programs and self-funded disability benefit plans.

(Continue to next page)

Sickness Benefits: The Hartford

- Contact Information
  - Phone: 1-800-205-7651
- Start your claim over the phone and then they will provide specific forms for you to follow up with
  - Medical Authorization Form (2 pages)
  - Supplemental Sickness Claim Form
- Processing & Payout Time
  - Quicker processing than RRB
  - Payout time is dependent on RRB

Therefore:

☐ **If any of my records contain information about alcohol or drug abuse, then, by checking this box, I hereby expressly allow my Benefits Managers to use or give out such information to evaluate, analyze, manage and/or administer the benefits program. I understand that the federal rules restrict any use of the Information to criminally investigate or prosecute any drug or alcohol abuse patient.**

I understand that once my Information is given out as allowed in this form, federal privacy laws may not protect it and it may be re-disclosed by The Hartford. I also understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. The Authorizations set forth herein expire two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage under the policy(ies) or benefit plan or program, except as may be reasonably necessary to prevent or detect perpetration of a fraud, adjudicate a benefits claim, respond to regulatory or similar complaints, or protect the personal safety of others or myself.

If I change my mind about this Authorization before that time is up, I can tell my Records Holders and The Hartford in writing that I do not want them to share any more information with other parties. If I revoke my Authorization by telling them in writing to stop sharing information with other parties, it will not change any actions they took before I revoked my permission. If I do not sign this Authorization, it will not affect how my health care providers treat me. However, if I do not sign, The Hartford may not be able to review my claim and determine whether I am eligible for benefits. This may result in denial of my request for benefits.

The Information released under this Authorization can be submitted to The Hartford electronically, by phone or fax, or by mail. I agree that a copy of this Authorization may be treated as a signed original. I understand that I am entitled to receive a copy of this Authorization upon request. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

NOTICE TO INFORMATION PROVIDERS:
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family members genetic tests, the fact that an individual or an individuals' family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. *Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.*

Signature of Claimant or Legal Representative **Date**

Name and Relationship to Claimant *(if signed by Legal Representative)*

Form must be signed and dated.

Sickness Benefits: The Hartford

- Contact Information
  - Phone: 1-800-205-7651
- Start your claim over the phone and then they will provide specific forms for you to follow up with
  - Medical Authorization Form
  - Supplemental Sickness Claim Form
- Processing & Payout Time
  - Quicker processing than RRB
  - Payout time is dependent on RRB

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 • If Yes, provide your return to work date: ________ • If No, when do you expect to return to work? ________
3. ( )	
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

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Sickness Benefits: Aflac

- Requirements
  - Enrolled in the AFLAC Program
  - On leave for 90+ days
- Forms
  - Initial Claim Form (1-6 pages)
  - Continuing Disability Form
    - Every 3 months is perpetuity
- Payout
  - $300 per month the first year
  - $3000 per month the second year

Continental American Insurance Company
PO Box 84075
Columbus, GA 31993
Phone: (888) 515-1904
Fax: (866) 849-2970
Email: groupclaimfiling@aflac.com

SHORT TERM DISABILITY CLAIM FORM
BROTHERHOOD OF MAINTENANCE WAY
GROUP 22644

CLAIMANT'S STATEMENT

PERSONAL DATA – SECTION I

NAME (Last, First, Middle Initial)		SOCIAL SECURITY NO.	EMPLOYEE ID	
ADDRESS		CITY	STATE	ZIP CODE
DATE OF BIRTH	SEX M F	PHONE NUMBER	EMAIL ADDRESS	

CLAIM DATA – SECTION II

DESCRIBE HOW AND WHERE THE ACCIDENT OCCURRED OR THE ONSET AND NATURE OF YOUR ILLNESS	WHAT WERE YOUR FIRST SYMPTOMS?

DATE YOU WERE FIRST TREATED FOR YOUR ILLNESS OR INJURY

TREATED BY:

Doctor: ______ Name / Street Address / City / State / Zip Code
______ Phone Number / Fax Number / Email

Hospital/Clinic: ______ Name / Street Address / City / State / Zip Code
______ Phone Number / Fax Number / Email

EMPLOYMENT DATA – SECTION III (To be completed by your Manager or Union Representative)

EMPLOYER'S NAME	SUPERVISOR/MANAGER/UNION REP.	PHONE NUMBER (WORK)	EMPLOYEE BY OCCUPATION
#22644 Brotherhood of Maintenance Way			
DATES EMPLOYEE DID NOT WORK FROM THROUGH	SUPERVISOR/MANAGER/UNION REP. SIGNATURE	DATE	

AUTHORIZATION

Several states require that the following statement appear on the claim forms:

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

For the purpose of evaluating my eligibility for insurance and eligibility for benefits under an existing policy/certificate including for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim form, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC) and its duly authorized representatives.

Disclosure of Health Information

Health information may be disclosed by any health care provider, health plan or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes.

Financial or credit history, earnings, or employment history may be disclosed by any entity, person or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or any consumer reporting agency.

Federal, state and local government organizations including but not limited to the veteran's Administration, Internal Revenue Service, Social Security Administration, Medicare or Medicaid agencies, may disclose health or financial information or records about me.

Any information CAIC obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. CAIC will not disclose the information unless permitted or required by those laws.

This authorization is valid for two (2) years from its execution or the duration of my claim, whichever is later. A copy of this authorization is as valid as the original. I know that I or my authorized representative may request a copy of this authorization and access to this this information.

This authorization may be revoked by me or my authorized representative at any time except to the extent CAIC has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If I revoke this authorization, CAIC may not be able to evaluate my claim or eligibility for benefits. I may revoke this authorization by sending written notice to: Continental American Insurance Company, Claims Department, P.O. Box 2274, Columbia, SC 29202.

You may refuse to sign this form; however, CAIC may not be able to evaluate or administer your claim without this authorization.

I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative

Claimant's Signature: **Date:**

Sickness Benefits: Aflac

- Requirements
  - Enrolled in the AFLAC Program
  - On leave for 90+ days
- Forms
  - Initial Claim Form (pages 1-6)
  - Continuing Disability Form
    - Every 3 months is perpetuity
- Payout
  - $300 per month the first year
  - $3000 per month the second year

Send to:
Continental American Insurance Company
PO Box 84075
Columbus, GA 31993
Phone: (888) 515-1904
Fax: (866) 849-2970
Email: groupclaimfiling@aflac.com

SHORT TERM DISABILITY CLAIM FORM
BROTHERHOOD OF MAINTENANCE WAY
GROUP 22644

ATTENDING PHYSICIAN'S STATEMENT (To be completed by your current treating physician)

PATIENT'S NAME | DATE OF BIRTH

WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT OCCUR? | DATE PATIENT CEASED WORK BECAUSE OF DISABILITY? | HAS THE PATIENT EVER HAD SAME OR SIMILAR CONDITION? ☐ YES ☐ NO DATE:

NAMES AND ADDRESSES/ REFERRING OR OTHER TREATING PHYSICIANS

DIAGNOSIS

DIAGNOSIS (INCLUDING COMPLICATIONS) | ICD CODE: | SUBJECTIVE SYMPTOMS | If PREGNANT (EDC):

OBJECTIVE FINDINGS (INCLUDING CURRENT X-RAYS, EKG'S, LABORATORY DATA AND ANY CLINICAL FINDINGS.)

PREGNANCY EDC LMP | **DATE OF DELIVERY** | METHOD OF DELIVERY ☐ VAGINAL ☐ CESAREAN | PLEASE LIST ANY **PREGNANCY COMPLICATIONS**

TREATMENT

DATE FIRST TREATED FOR THIS CONDITION | LAST DATE TREATED FOR THIS CONDITION | FREQUENCY ☐ WEEKLY ☐ MONTHLY ☐ OTHER

NATURE OF TREATMENT (SURGERY AND MEDICATIONS PRESCRIBED, IF ANY.) | DID PATIENT HAVE SURGERY? ☐ NO ☐ YES DATE: DESCRIBE SURGERY:

PROGNOSIS

HAS THE PATIENT: ☐ RECOVERED? ☐ IMPROVED? ☐ UNCHANGED? ☐ RETROGRESSED? | IS THE PATIENT: AMBULATORY? HOUSE CONFINED? BED CONFINED? HOSPITAL CONFINED?

HAS THE PATIENT BEEN HOSPITAL CONFINED? ☐ NO ☐ YES CONFINED FROM TO | IF YES, GIVE NAME AND ADDRESS OF HOSPITAL:

IS THE PATIENT NOW TOTALLY DISABLED FROM? PATIENT'S JOB? ☐ NO ☐ YES ANY OTHER WORK? ☐ NO ☐ YES | DATE PATIENT BECAME DISABLED DUE TO PRESENT CONDITION?

WHEN DO YOU EXPECT A FUNDAMENTAL OR MARKED CHANGE IN THE PATIENT'S CONDITION? ☐ 1 MO. ☐ 1-3 MO. ☐ 3-6 MO. ☐ 6-9 MO. ☐ 9-12MO. ☐ NEVER | WHEN DO YOU ANTICIPATE A RETURN TO WORK?

IMPAIRMENTS

PHYSICAL IMPAIRMENTS (As defined in the 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%)
☐ CALLS 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%)

RESTRICTIONS AND LIMITATIONS (What specific activities is the patient incapable of performing)

REMARKS

REMARKS (Additional comments regarding the patient's condition)

"I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief."

NAME (Attending Physician) PLEASE PRINT	DEGREE	TELEPHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE
SIGNATURE	DATE	MEDICAL ID#	

Sickness Benefits: Aflac

- Requirements
  - Enrolled in the AFLAC Program
  - On leave for 90+ days
- Forms
  - Initial Claim Form (pages 1-6)
  - Continuing Disability Form
    - Every 3 months is perpetuity
- Payout
  - $300 per month the first year
  - $3000 per month the second year

AUTHORIZATION TO OBTAIN INFORMATION

Send to:
Continental American Insurance Company
Post Office Box 84075
Columbus, GA 31993

Phone: (888) 515-1904
Fax: (866) 849-2970
Email: groupclaimfiling@aflac.com

Primary Certificate Holder Name:	**SSN**(optional):		**Date of Birth:**
Certificate Number(s):			
Address:	**City:**	**State:**	**Zip:**
Name of Individual Subject to Disclosure (If not the primary Certificate Holder):			**Date of Birth:**
Relationship to Primary Certificate Holder: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Child ☐ Stepchild ☐ Grandchild			

I. Authorization:
For the purpose of evaluating my *eligibility for insurance and for benefits* under an existing certificate, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application for coverage and/or claim form, I hereby authorize the disclosure of the following information(defined below) about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC), or any person or entity acting on its part, to include American Family Life Assurance Company of Columbus and American Family Life Assurance Company of New York (collectively, "Aflac).

II. Disclosure of Health Information:
Health information may be disclosed by any health care provider, health plan (including CAIC or Aflac, with respect to other CAIC or Aflac coverages) or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. CAIC will not disclose the information unless permitted or required by those laws.

III. Rights and Expiration:
I understand that I may revoke this authorization at any time, except to the extent that CAIC or Aflac has taken action in reliance on this authorization. If I revoke this authorization, CAIC may not be able to evaluate my application for coverage and/or claim. To revoke this authorization, I must provide a written and signed revocation to CAIC at the address or fax number above. Unless otherwise revoked, this authorization shall remain in effect for two (2) years from the date signed or upon my death, whichever occurs first. I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

IV. Notice:
I understand that CAIC is not conditioning payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that if the information disclosed is protected health information relating to a health plan and the person or entity receiving the information is a not a health care provider or health plan covered by federal privacy regulations, the information disclosed may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

- **If records are on an adult dependent, (e.g. spouse, child over 18), the dependent must sign this form.**
- **If records are on a minor child the natural parent or legal guardian must sign on their behalf.**

Signature of Individual Subject to Disclosure — Date Signed

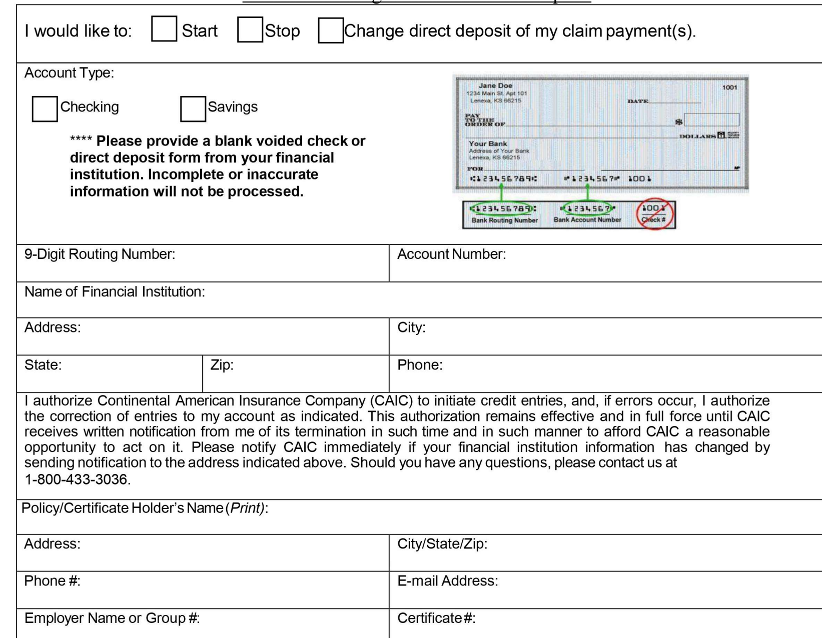
Legal Representative's Printed Name — Legal Representative's Signature — Legal Relationship — Date

***If signed by a legal representative (e.g. Legal Guardian, Estate Administrator, Power of Attorney*

Sickness Benefits: Aflac

- Requirements
  - Enrolled in the AFLAC Program
  - On leave for 90+ days
- Forms
  - Initial Claim Form (pages 1-6)
  - Continuing Disability Form
    - Every 3 months is perpetuity
- Payout
  - $300 per month the first year
  - $3000 per month the second year

Electronic Funds Transaction Authorization



Send to:
Continental American Insurance Company
Post Office Box 84075
Columbus, Georgia 31993

Phone: (800) 433-3036 Fax (866) 849-2970
Email: groupclaimfiling@aflac.com

Authorization Agreement for Direct Deposit

I would like to: ☐ Start ☐ Stop ☐ Change direct deposit of my claim payment(s).

Account Type:

☐ Checking ☐ Savings

****** Please provide a blank voided check or direct deposit form from your financial institution. Incomplete or inaccurate information will not be processed.**

9-Digit Routing Number:		Account Number:
Name of Financial Institution:		
Address:		City:
State:	Zip:	Phone:

I authorize Continental American Insurance Company (CAIC) to initiate credit entries, and, if errors occur, I authorize the correction of entries to my account as indicated. This authorization remains effective and in full force until CAIC receives written notification from me of its termination in such time and in such manner to afford CAIC a reasonable opportunity to act on it. Please notify CAIC immediately if your financial institution information has changed by sending notification to the address indicated above. Should you have any questions, please contact us at 1-800-433-3036.

Policy/Certificate Holder's Name (*Print*):	
Address:	City/State/Zip:
Phone #:	E-mail Address:
Employer Name or Group #:	Certificate #:

****By providing your e-mail address above, you consent to the use of electronic transactions in connection with your CAIC policies, contracts, and/or accounts to the extent available and permitted by law (which may include, but not limited to: invoices, claim correspondence, contracts, surveys, and other materials that CAIC is, or may be, legally required to deliver to you)*

Note: Forms received without signature will not be processed. Electronic signatures not accepted.

Policy/Certificate Holder Signature *(Required)* **Date Signed:**

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. Aflac is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups sitused in California, coverage is underwritten by Continental American Life Insurance Company. For groups sitused in New York, coverage is underwritten by American Family Life Assurance Company of New York.

Continental American Insurance Company • 1600 Williams St • Columbia, South Carolina 29201 • 1-800-433-3036 toll-free • 1-866-849-2970 fax

EFT Form 2016

Sickness Benefits: Aflac

- Requirements
  - Enrolled in the AFLAC Program
  - On leave for 90+ days
- Forms
  - Initial Claim Form (pages 1-6)
  - Continuing Disability Form
    - Every 3 months is perpetuity
- Payout
  - $300 per month the first year
  - $3000 per month the second year

FRAUD WARNING NOTICES

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

ALASKA: A person who knowingly and with intent to injury, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.	**IDAHO:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.
ARIZONA: 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.	**INDIANA:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing Any false, incomplete, or misleading information commits a felony.
ARKANSAS: 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.	**KENTUCKY:** 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.
CALIFORNIA: For your protection California law requires the following to appear on this form: 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.	**LOUISIANA:** 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.
COLORADO: 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.	**MAINE:** 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. **MARYLAND:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or 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.
DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.	**MINNESOTA:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilt of a crime.
DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.	**NEW HAMPSHIRE:** 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 in RSA 638:20.
FLORIDA: 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.	**NEW JERSEY:** Any person who knowingly files astatement of claim containing any false or misleading information is subject to criminal and civil penalties.

Sickness Benefits: Aflac

- Requirements
  - Enrolled in the AFLAC Program
  - On leave for 90+ days
- Forms
  - Initial Claim Form (pages 1-6)
  - Continuing Disability Form
    - Every 3 months is perpetuity
- Payout
  - $300 per month the first year
  - $3000 per month the second year

FRAUD WARNING NOTICES (CONT.)
For use with Claim Forms
PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

NEW MEXICO: 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 civil fines and criminal penalties.	**TENNESSEE:** It is a crime to knowingly provide false, incomplete or misleading information to aninsurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
NEW YORK: 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 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 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.	**TEXAS:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of acrime and may be subject to fines and confinement instate prison.
OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.	**VIRGINIA**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.	**WASHINGTON:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
OREGON: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer,submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.	**RHODE ISLAND 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.
PENNSYLVANIA: Any person who knowingly and withintent to defraud any insurance company or other person files an 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.	**ALL OTHER STATES:** 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 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.
PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars($5,000) and not more than ten thousand dollars($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.	

Sickness Benefits: Aflac

- Requirements
  - Enrolled in the AFLAC Program
  - On leave for 90+ days
- Forms
  - Initial Claim Form
  - Continuing Disability Form
    - Every 3 months is perpetuity
- Payout
  - $300 per month the first year
  - $3000 per month the second year

CONTINENTAL AMERICAN INSURANCE COMPANY
Post Office Box 84075 * Columbus, GA. 31993
Phone (800) 433-3036 * Fax (866) 849-2970

SUPPLEMENTAL CLAIM FORM (CONTINUING DISABILITY)

(Please have completed for support of continued disability) **Claim Number:**

PART A: POLICYHOLDER'S STATEMENT

NAME: | SOCIAL SECURITY/ ID#: | DOB:

PHONE #: (INCLUDING AREA CODE) | ADDRESS: Please include apartment/unit number if applicable | EMAIL ADDRESS:

☐PLEASE CHECK BOX IF PERMANENT ADDRESS CHANGE

DATES YOU WERE CONSIDERED TOTALLY DISABLED: FROM: THROUGH: | DATES YOU WERE CONSIDERED PARTIALLLY DISABLED: FROM: THROUGH: | DATE YOU RETURNED OR EXPECT TO RETURN TO WORK: ☐ FULL TIME ☐ PART TIME/ LIGHT DUT

* By providing your e-mail address above, you consent to the use of electronic transactions in connection with your CAIC policies, contracts, and/or accounts to the extent available permitted by law (which may include, but not limited to: invoices, claim correspondence, contracts, surveys, and other materials that CAIC is, or may be, legally required to deliver to you).

I, the undersigned, do hereby warrant the foregoing answers and statements to be complete and true

POLICYHOLDER'S SIGNATURE: ***DATE:***

PART B: EMPLOYER'S STATEMENT

DATES EMPLOYEE WAS CONSIDERED TOTALLY DISABLED: FROM: THROUGH:

DATES EMPLOYEE WAS CONSIDERED PARTIALLLY DISABLED: FROM: THROUGH:

If working light duty or part time, was the employee earning more than 80% of the pre-disability salary?

Please provide dates, hours worked, and earnings if the employee returned working part-time/light duty:

DATE EMPLOYEE RETURNED OR EXPECT TO RETURN TO WORK FULL DUTY: FULL-TIME PART-TIME

COMPANY NAME: | TELEPHONE NUMBER: | NAME/TITLE OF REPRESENTATIVE COMPLETING THIS FORM: | EMPLOYEE'S OCCUPATION AT LAST DATE WORKED:

ADDRESS:

EMPLOYER REPRESENTATIVE AUTHORIZED SIGNATURE: ***DATE:***

PART C: ATTENDING PHYSICIAN STATEMENT (To be completed by physician assessing return to work capability)

DIAGNOSIS: | PROVIDE ALL DATES YOU HAVE TREATED THE PATIENT FOR THIS CONDITION:

NATURE OF SICKNESS OR INJURY; COMPLICATIONS PREVENTING THE PATIENT FROM RETURNING TO WORK:

IF PREGNANCY RELATED, HAS THE PATIENT DELIVERED?
DELIVERY DATE: __________
METHOD OF DELIVERY:
☐VAGINAL
☐C-SECTION

PLEASE LIST ANY COMPLICATIONS RELATED TO THIS PREGNANCY THAT WOULD EXTEND DISABILITY: (PREVENT PATIENT FROM PERFORMING NORMAL JOB FUNCTIONS)

WAS THE PATIENT TREATED BY OR REFERRED TO FOR ANY OTHER PHYSICIANS FOR THIS CONDITION? | IF YES, PLEASE PROVIDE PHYSICIAN NAMES, ADDRESSES, AND TELEPHONE NUMBERS:

DATES PATIENT WAS CONSIDERED TOTALLY DISABLED: FROM: THROUGH: | DATES PATIENT WAS CONSIDERED PARTIALLLY DISABLED: FROM: THROUGH: | DATE PATIENT RELEASED TO RETURN TO WORK: **(Please give estimate if not able to determine at this time)**

HAS THE PATIENT: (Please circle selection)
☐RECOVERED ☐IMPROVED ☐UNCHANGED ☐RETROGRESSED

DISABILITY RELATES TO:
☐PATIENT'S JOB
☐ANY OTHER WORK

WHEN DO YOU EXPECT A FUNDAMENTAL OR MARKED CHANGE IN THE FUTURE:
☐1 MO. ☐1-3 MO. ☐3-6 MO. ☐6-12 MO. ☐NEVER

WHAT ARE THE **SPECIFIC RESTRICTIONS AND LIMITATIONS** AS IT RELATES TO THE PATIENT'S OCCUPATION AND DISABLING CONDITION?

WILL THE PATIENT BE ABLE TO PERFORM THE REGULAR DUTIES OF HIS/ HER OCCUPATION WITH THE ABOVE RESTRICTIONS IN PLACE? ☐YES ☐NO

AUTHORIZED SIGNATURE OF PHYSICIAN

Name (Please Print) | **Telephone Number**

Address | **Medical ID#**

"I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief."

SIGNATURE OF PHYSICIAN: ***DATE:***

COVID Leaves
(short-term)

- **Application of Sickness Benefits**
  - Pages 1-2, same instructions
  - Page 3 (Statement of Sickness)
    - Not Required
    - If positive, attach copy of test results
  - Pages 4-5, not needed
- **Direct Deposit Form**
  - Same instructions for 7+ day leave
  - For a less than 7-day leave, not needed

- **Statement of Claimant**
  - If you test positive
    - I, (name), am filing for RRB sickness benefits due to **being held out of service** due to testing positive for COVID-19.
  - If you are exposed
    - I, (name), am filing for RRB sickness benefits due to **being held out of service** for quarantine purposes due to COVID-19 exposure.

Leaves Administration:

Setting up a Leave

- **Obtain a doctor's note**
  - Requirements:
    - On doctor's letterhead/prescription pad
    - States why you are unable to return to work
    - Provides either a return to work or next appointment date
- **Send doctor's note to Leaves Admin:**
  - Fax: (817) 867-5759
  - Email: leavesadmin@bnsf.com
- Send follow up email to verify receipt and obtain leave end date

Extending a Leave

- **Receiving your leave end date:**
  - Provided to you through:
    - Email- response to your follow up
    - USPS- comes in a certified letter
  - Leaves will be granted for a max of 60 days
- **The week before your leave expires:**
  - If you are returning to work, do nothing
  - If you will still be out, extend your leave
    - Same process as setting your leave up
- Failure to extend leave is automatic termination

My name is ____ and my employee number is ____. Could you please verify that you received my doctors note requesting to (start/extend) my leave (via fax/attached to this email)? Also, could you provide me with an end date for my (new/extended) leave.

Contacting RRB

Phone

- Call 877-772-5772
  - Wait on hold
    - Could be 4+ hours
    - Could be disconnected and lose your spot in line
  - Request a callback & be placed in the queue
    - If there are spaces in the que available, a recorded prompt will ask you to join the queue
    - Call from 7am-9am, the que fills up quickly

Include in Email

Personal Information

- Name. Date of Birth, Last 4 of SSN, Phone Number
  - Often, they will call back instead of emailing

Your Situation

- When your leave started, when and how you sent the forms, what correspondence (if any) you've received from RRB

Your Question/Problem

- Provide as much detail as possible to avoid back and forth to get to a solution quicker.

Email/Secure Messaging

- Locate your field office's email/secure messaging portal
  - Go to rrb.gov
  - Scroll down and select "Field Office Locator"
  - Enter your zip code
  - Click on the blue underlined location of your field office
  - To send a secure message:
    - Under contact info select " Send a Secure Message"
    - Follow prompts to submit message
  - To locate an email address,
    - Click the downloadable pdf titled "(your city) Filed Office"
    - Locate email address in the contact information toward the top of the page
    - Draft Email (instructions to the left) and send

General Best Practices:
Protecting Yourself

- **Conduct business over email**
  - Leaves a paper trail for future use
  - Even if you call, follow it up with an email summarizing your call and ask them to confirm that your summarization of the call was correct.
- **Get advised on your specific situation**
  - Talk to your vice general chairman
  - Call the system office
    - (402) 463-0234, ask for Megan
- **Don't wait until the last minute**
  - Submit forms as soon as possible
    - Ideally within a week of your leave start date
      - NEVER before your leave start date
- **Keep accurate records**
  - Keep all correspondence including:
    - RRB Paperwork
    - Hartford Paperwork
    - Aflac Paperwork
    - Doctor's Notes
    - Leaves Admin Letters & Email Correspondence
    - Any communications with the carrier
      - Screenshots of texts with supervisors
  - Storage Options:
    - Personal files at home
    - Membership profile at the system office
      - Fax: (402) 463-0226
      - Email: megan@bmwebsd.org (pictures okay)
      - Mail: Burlington System Division, 1113 E South St. Hastings, NE 68901