SMART Voluntary Short Term Disability Plan
Rail Member Instructions for Filing a VSTD Claim

1. Complete Section 1 of the Claim Form.

   Be sure to complete all requested information and sign and date the form where indicated. Incomplete forms will be returned to you and will delay payment of your claim. Please double-check that **ALL** information is provided and that you wrote your information clearly. **YOU NEED NOT SEND YOUR PAY STUB OR ITEMIZED EARNINGS STATEMENT TO THE PLAN UNLESS IT IS REQUESTED BY THE ADMINISTRATION OFFICE.**

2. Have your physician complete Section 2 of the Claim Form.
   If your disability is due to an accident or if you anticipate any form of settlement, you may be asked to complete the SMART VSTD Reimbursement Agreement. This form is located under FORMS on the VSTD website, www.smart-vstd.com.

3. Make a copy of the completed Claim Form for your records.

4. Mail, fax or email your completed Claim Form to the SMART VSTD Plan as indicated on the Claim Form. Contact the Plan using the toll-free number provided on the Claim Form if you have any questions about your claim.

SMART Voluntary Short Term Disability Plan Rail Member Claim

Instructions: You must complete Section 1 of this form and have your Physician complete Section 2. Once all sections are fully completed, you should mail, fax or email the form to:

SMART VSTD Plan
PO Box 1449, Goodlettsville, TN 37070-1449
Fax: (615) 859-0201
Email: support@smart-vstd.com

For assistance, you may contact the office of the Plan toll-free at: (844) 880-1071

SECTION 1: TO BE COMPLETED BY MEMBER

1. Member name (last, first, M.I.)	2. Social Security No.	3. Birth Date / /	4. Gender [ ] M [ ] F
5. Member Street Address	5.a. City	5.b. State	5.c. Zip Code

6. Local Union Number	7. Phone Number	8. Email Address

9. Date last worked due to your disability / /	10. Date you returned to work / /	11. If not yet returned, date you expect to return / /	12. Disability Due to: Illness [ ] Injury [ ]

13. If disability is due to injury, what type? Please provide complete details of accident, including location, date and time(attach a separate sheet if necessary)

14. Please provide your wage information. Amount $_____ [ ] Hour [ ] Week [ ] Year

15. Other Benefits:

Is claim being made under FELA for this disability?	[ ]YES [ ]NO
Have you settled?	[ ]YES [ ]NO
Date of Settlement _____	
Is claim being made for Worker's Compensation?	[ ]YES [ ]NO
Are you covered by a railroad sponsored retirement plan?	[ ]YES [ ]NO
Does the retirement plan contain a disability provision?	[ ]YES [ ]NO
Are you receiving or will you be applying for a disability retirement benefit for this disability?	[ ]YES [ ]NO
Are you receiving or will you be applying for a Social Security disability benefit?	[ ]YES [ ]NO

16. Describe all other income you are receiving:	Amount	Date began	Date ended
[ ]YES [ ]NO State Disability			
[ ]YES [ ]NO Retirement			
[ ]YES [ ]NO Worker's Compensation			
[ ]YES [ ]NO FELA			
[ ]YES [ ]NO Other (describe)_____			

I authorize the release to or by the SMART Voluntary Short Term Disability Plan (SMART VSTD) any medical or insurance information required to process my claim. I understand that any information obtained pursuant to this authorization will be used only to evaluate my claim and may be transferred to any organization or person employed by or representing SMART VSTD to assist with this purpose. This authorization is valid for the duration of my claim. I understand I have a right to request and receive a copy of this authorization. A photocopy of this authorization is as valid as the original.

The above statements are true and complete to the best of my knowledge and belief. (Your signature is required for benefit consideration.)

Member Signature

X_____

Date

_____

SMART Voluntary Short Term Disability Plan
Rail Member Claim Form

SECTION 2: TO BE COMPLETED BY PHYSICIAN

Note to Physician: Completion of this form will assist your patient in presenting a claim for short term disability benefits. Please complete all areas of the form; if a section is non-applicable, please enter N/A in the response area.

1. Patient's name (last, first, M.I.)			2. Birthdate
3. Primary diagnosis	4. ICD-9/ICD-10/DSM IV		
5. Secondary and additional diagnoses with codes			
6. Subjective complaints		7. Objective findings	
8.a. Has patient ever had same or similar condition? [ ] Yes [ ] No	8.b. If yes, please specify date of treatment	9. Did injury or illness arise out of, or in course of, employment for wages or profit? [ ] Yes [ ] No [ ] Unknown If yes, please explain:_____	
10.a. Is Disability due to pregnancy? [ ] Yes [ ] No	10.b. Estimated date of delivery		
11.a. Was patient hospitalized? [ ] Yes [ ] No	11.b. If yes, please provide date of confinement	11.c. Name of hospital/facility	
12.a. Nature of surgical procedure, if any. (Describe in full.)		12.b. Date performed	
13. Date patient first unable to work	14. Date of first visit	15. Date of latest visit	16. Patient's present condition [ ] Recovered [ ] Improved [ ] Unchanged [ ] Regressed
17. Frequency of visits [ ] Weekly [ ] Monthly [ ] Other: _____			
18. Treatment Plan		19. Functional impairments	
20. Current medications and dosages		21. Patient released to return to work? [ ] Yes [ ] No	
22. Is patient a suitable candidate for a rehabilitation program? [ ] Yes [ ] No		23. Expected date able to return to full duty	

24. Physician printed name		25. Physician specialty	
26.a. Physician street address	26.b. City	26.c. State	26.d. Zip Code
27. Physician phone number	28. Physician fax number	29. Physician email address	
Physician signature **X** _____		Date	

SMART VOLUNTARY SHORT TERM DISABILITY PLAN

c/o Southern Benefit Administrators, Inc.
P.O. Box 1449
Goodlettsville, TN 37070

AUTHORIZATION FOR AUTOMATIC TRANSFERS

I hereby authorize the **SMART Voluntary Short Term Disability Plan**, hereinafter called the PLAN, to deposit into my checking or savings account as directed and, if necessary, to adjust or reverse a deposit for any payment entry made to my account in error for any amount payable to me as allowed by the PLAN as a result of my disability claim.

BANK NAME:_____ **BRANCH:**_____

CITY:_____ **STATE:** _____ **ZIP:** _____

CHECKING_____ **SAVINGS**_____

NAME ON ACCOUNT: _____
(Please Print)

ACCOUNT NUMBER: _____

ROUTING/ABA NO. _____

SIGNATURE: _____

DATE: _____

This authorization will remain in full force and effect until further notice to the PLAN by written notification from me in such time and in such manner as to afford the PLAN and DEPOSITORY a reasonable opportunity to act on it. It is also understood that direct deposits will be terminated upon death or separation from the PLAN.

ATTACH A VOIDED CHECK HERE.