SMART Voluntary Short Term Disability Plan
Late Entry Application

Instructions: Complete this form fully and accurately and mail or fax the form to:

SMART VSTD Plan
PO Box 1449, Goodlettsville, TN 37070-1449
Fax: (615) 859-0201

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

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. Phone Number	7. Cell Phone Number	8. Email Address	
9. Craft: [ ] Rail Member [ ] Bus Member		10. Local Union	

Medical Questionnaire

For the purpose of the following medical questions, the term "medical or social practitioner" includes but is not limited to: a doctor, nurse, psychologist, psychiatrist, social worker, chiropractor, podiatrist, therapist, pathologist, dentist, optometrist, osteopath, clergy, Christian Science practitioner, or any person affiliated with a self-help program such as Alcoholics Anonymous, a substance abuse program, or a weight loss program.

1. Are you pregnant? [ ] YES [ ] NO
   If yes, expected due date: _____

2. Do you smoke or use tobacco? [ ] YES [ ] NO
   If yes, what type?_____

3. In the past 10 years, have you ever:
   a. Had high blood pressure or high cholesterol? [ ] YES [ ] NO
      If yes, list last three readings:
      _____
   b. Had heart disease, cancer, diabetes, arthritis, or asthma? [ ] YES [ ] NO
   c. Had counseling by a medical or social practitioner for an emotional, mental or nervous condition? [ ] YES [ ] NO
   d. Been treated for alcohol or chemical dependency, or been convicted for driving while intoxicated? [ ] YES [ ] NO

4. Have you ever been diagnosed by, or received treatment from, a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC), or tested positive for antibodies to the Human Immune Deficiency virus? [ ] YES [ ] NO

5. In the past three years have you been prescribed medication? [ ] YES [ ] NO

6. In the past 10 years have you had an inpatient admission and/or outpatient surgery? [ ] YES [ ] NO

(OVER)

7. During the past three years have you sought medical treatment, or been advised by a medical or social practitioner to seek treatment, for any condition not indicated by your answers to the preceding six questions? [ ] YES [ ] NO

8. Have you ever been rated or declined for, or refused reinstatement or renewal of, life or health insurance? [ ] YES [ ] NO
If yes, list date and reason:_____

_____

9. In the past three years, have you been engaged in or do you contemplate being engaged in sports or hobbies such as aviation, scuba diving, sky diving, racing or similar activities? (please list)_____ [ ] YES [ ] NO

_____

10. Have you ever filed a FELA claim? _____ If yes, did you settle? _____
Date of Settlement _____ Date of Injury _____ Diagnosis_____

If you answered yes to any questions 3 through 7, provide details below. If additional space is needed, please attach a separate page including your signature and date.

Question No.	Illness or Injury	Dates of Treatment	Any Remaining Effects	Name of Medication and Dosage	Name and Address of Physician

AGREEMENT AND AUTHORIZATION

I understand that in order for SMART VSTD to accept or decline this application, all of the information requested on this application must be completed. In the event that I have not correctly or fully completed this application, my signature shall authorize SMART VSTD or its designee to obtain the necessary information for me, should it so choose, and to complete that information on this application. I realize that SMART VSTD reserves the right to accept or decline this application and that no right whatsoever is created by this application.

For the purpose of evaluating my application for coverage, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau, Inc. or other organization, institution or person that has any records or knowledge of me or my health to give SMART VSTD any such information. I understand that this information will be used by SMART VSTD to determine eligibility for coverage. This information includes information about drugs, alcoholism or mental illness. This authorization will be valid from the date signed for a period of two-and-one-half years. A photocopy of this authorization will be as valid as the original. I understand that I may request a photocopy.

I certify that I have read, or have had read to me, this completed application and that all information is true and complete to the best of my knowledge. I understand that any misrepresentation or significant omission may void my coverage.

_____

SIGNATURE OF APPLICANT DATE