Memorandum

New York City Transit

Date: April 5, 2007

To: TWU, Local 100 Represented Employees

From: MTA New York City Transit

Subject: **Short Term Disability Informational Notice and Claim Form (DB 450)**

If you are unable to work because of a non-occupational illness or injury, you may be entitled to disability benefits. This informational notice is to advise you of your contractual rights to short term disability benefits.

Benefit: Short Term Disability (STD) benefits are payable for non-work related injury or illness (including disability due to pregnancy) beginning the 8th consecutive day of disability following the exhaustion of all contractually defined paid sick leave benefits. Benefits are equivalent to 50% of average weekly wages (over the eight weeks prior to the disability) up to a maximum of $170 per week. The disability period and STD payments will not exceed a total of 26 weeks from the date of disability or 26 weeks in a 52 week period.

Claims: Effective May 1, 2006, you may file a written notice and proof of disability on a DB-450 claim form with your designated supervisor. Claims for the periods between ***May 1, 2006*** and the present (retroactive) should be filed immediately but no later than June 15, 2007. Prospectively, claims should be filed within 30 days from the first day of your disability. If you file late, you may not be paid for any disability period more than two weeks before the claim is filed. Late filings may be excused if it is shown that it was not reasonably possible to file earlier, but in no event should you wait more that 26 weeks to file a claim. Form DB-450 should be used for both retroactive and prospective claims.

You may obtain form DB-450 from your depot or division, Transit's Website (TENS) or your union. Filing a claim through your designated supervisor is your responsibility. First, **complete and sign** Part A, *Claimant's Statement of form DB-450.* Next, have your attending **physician complete and sign** Part B, *Health Care Provider's Statement.* Lastly, file form DB-450 with your designated supervisor and retain a copy for your records.

Medical Treatment: You are entitled to be treated by any physician, chiropractor, dentist, nurse-midwife, podiatrist or psychologist of your choice. Medical bills may be covered under your contractually provided health benefit plan but are not covered under this STD benefit.

General Guidelines for SHORT TERM DISABLITY (STD)

Package:

Short Term Disability pre-application (completed by Timekeeping Unit)

- Employee Benefits Department check list (completed by Employee Benefits)
  Employee acknowledgement letter (signed by Employee)
- DB-450 Claim form (***This is a three part form***: **a)** completed by employee; **b)** completed by provider; **c)** completed by Timekeeping Unit)

All Forms must be submitted to the NYC Transit Employee Benefits Department at 180 Livingston, Room 6008 Brooklyn, NY 11201. (DO NOT mail directly to NYS INSURANCE FUND.

Basic Rules:

1) Employee must use all of their sick balance.
2) If the employee is eligible, the employee must apply for 60% sick, the 60% sick must be used before Short Term Disability can be paid **(except if disapproved).**
3) Short Term Disability payment will commence:
   a) with the eighth day if unpaid and the other requirements out lined in items 1 to 3 above are met.
   b) or the first unpaid day after the seventh day of disability and the other requirements out lined in items 1 to 3 above are met.
4) The employee may request but ***is not*** required to use vacation.
5) The Short Term Disability is 26 weeks pay in a 52-week period.
6) Each new instance of disability must meet the requirements of items 1 to 3, as well as, each instance of STD is subject to a seven day waiting period.

Employee's Responsibility:

1) Complete part A of Form DB-450
2) Employee is responsible for the Medical portion in Part B of Form DB-450
3) **Submit form to Timekeeping Unit for completion.**

Timekeeper's Responsibility:

1) Check that all necessary information is completed and signed by employee and physician.
2) Timekeepers must fill out the Short Term Disability Pre-application. This Form is to be signed by designated management personnel.
3) Make sure that line 7d in Part B of form DB-450 is filled in by the employee's attending physician or medical care practitioner.
4) Complete Part C of Form DB-450 including the section marked *"Weekly Wages 8 Weeks prior to Disability")*. Gross wages includes all 01', differentials, longevity, shoe/tool, etc.
5) Line 13: answer *yes* if wages are being paid (e.g. vacation in lieu of sick, AVA, etc.
6) Line 14: answer ***no*** -- Transit is not requesting reimbursement of payment.
7) Line 20: answer *yes* -- if employee is being paid regular sick (please provide dates).
8) Line 21: answer *yes* – if employee is being paid 60% sick (please provide dates).
9) Send the completed package to Employee Benefits.

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

CLAIMANT: READ THE FOLLOWING INSTRUCTIONS CAREFULLY

1. Use this form if you become sick or disabled while employed or if you become sick or disabled within four (4) weeks after termination of employment. Use claim form DB-300 if you become sick or disabled after having been unemployed more than four (4) weeks.
2. You must complete all items of part A – The "CLAIMANT'S STATEMENT". Be accurate. Check all dates.
3. Be sure to date and sign your claim (see item 12). If you can not sign this form, your representative may sign it in your behalf. In that event, the name, address, and representative's relationship to you should be noted under the signature.
4. Do Not Mail this Claim unless your Health care Provider Completes and Signs Part B – The "HEALTH CARE PROVIDER'S STATEMENT."
5. Your completed claim should be mailed WITHIN 30 DAYS after you become sick or disabled to your last employer or your last employer's insurance company.
6. Make a copy of this completed form for your records before you submit it.

PART A - CLAIMANT'S STATEMENT (Please Print or Type) ANSWER ALL QUESTIONS

Social Security Number

1. Name _____ (First / Middle / Last)

2. Address _____ (Number / Street / City or Town / State / Zip code / Apartment Number)

3. Tel. No. ( ) _____ 4. Date of Birth _____ 5. Married (Check one) ☐ Yes ☐ No

6. My disability is (if injury, also state **how**, **when**, and **where** it occurred) _____

7. I became disabled on _____ (Month / Day / Year) 7.a I worked on that day (Check one) ☐ Yes ☐ No

7.b I have since worked for wages or profit. ☐ Yes ☐ No If "Yes" give dates: _____

8. Give name of **last** employer. If **more than one employer** during the last eight (8) weeks, name **ALL** employers.

EMPLOYERS			Dates of Employment						Average Weekly Wages (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, Etc)
			FROM			THROUGH			
BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	Mo.	Day	Year	Mo.	Day	Year	

9. My job is or was (**Occupation**) _____ Name of union and local Number, if member _____

10. For the period of Disability covered by this claim:
   a. Are you receiving wages, salary, or separation pay _____ ☐ Yes ☐ No
   b. Are you receiving or claiming:
      (1) Workers' compensation for work-connected disability _____ ☐ Yes ☐ No
      (2) Unemployment Insurance Benefits _____ ☐ Yes ☐ No
      (3) Damages for personal injury _____ ☐ Yes ☐ No
      (4) Benefits under the Federal Social Security Act for long-term disability _____ ☐ Yes ☐ No

   IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 10a OR 10b, COMPLETE THE FOLLOWING:

   I have ☐ received ☐ claimed from: _____ for the period _____ to _____

11. I have received disability benefits for another period or periods of disability within the 52 weeks immediately before my present disability began _____ ☐ Yes ☐ No

    If "Yes", fill in the following: I have been paid by _____ from _____ to _____

12. I have read the instructions above. I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled; and that the forgoing statements, including any accompanying statements, are to the best of my knowledge true and complete.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AN IMPRISONMENT.

CLAIM SIGNED ON: _____
DATE CLAIMANT'S SIGNATURE

If signed by other than claimant, PRINT below: name, address, and relationship of representative.

Disclosure of Information: The Board will not disclose any information about your case to any unauthorized party without your consent. If you choose to have such information disclosed to an unauthorized party, you mast file with the Board an original signed form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records, or an original signed, notarized authorization letter. You may telephone your local WCB office to have Form OC-110A sent to you, or you may download it from our web page, www.wcb.state.ny.us. It can be found under the heading Common Forms Online. Mail the completed authorization form or letter to the address given below.

IF YOU HAVE ANY QUESTIONS ABOUT CLAIMING DISABILITY BENEFITS, CONTACT THE NEAREST OFFICE OF THE NYS WORKERS' COMPENSATION BOARD, OR WRITE TO: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, NY 12241-0005.

SI TIENE DUDASRELACIONADAS CON LA RECLAMACION DE BENEFICIOS POR INCAPACIDAD, COMUNIQUSE CON LA OFICINA MAS CERCANA DE LA JUNTA DE COMPENSACION OBRERA DE NUEVA YORK O ESCRIBA A: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, NY 12241-0005.

PART B – HEALTH CARE PROVIDER'S STATEMENT

NOTICE OF PROOF OF CLAIM FOR DISABILITY BENEFITS - IMPORTANT: Use this form only when the claimant becomes sick or disabled while employed or becomes sick or disabled within four (4) weeks after termination of employment. Otherwise use the green claim form DB-300.

PART B – Health Care Provider's Statement (Please Print or Type) – The Health Care Provider's Statement must be filled in completely and the Form mailed to the Insurance Carrier or Self-Insured employer, or returned to the claimant within SEVEN DAYS of the receipt of the Form. For item 7d, give the approximate date. Make some estimate. If the Disability is caused by or arising in connection with pregnancy, enter the estimated delivery date under "Remarks."

1. Claimant's Name: _____ (First / Middle / Last) 2. Age _____ 3. Sex ☐ Male ☐ Female

4. Diagnosis / Analysis: _____ Diagnosis Code: _____

a. Claimant's Symptom's: _____

b. Objective Findings: _____

c. If Disability is **pregnancy** related, enter **ESTIMATED DELIVERY DATE** _____

5. Claimant Hospitalized? ☐ Yes ☐ No Date from: _____ to _____

6. Operation indicated? ☐ Yes ☐ No a. Type _____ b. Date _____

7 Enter ***Dates*** for the following:

	Date: Month	Day	Year
a. Date of your **first treatment** for this Disability			
b. Date of your **most recent treatment** for this Disability			
c. Date claimant was **unable to work** because of this Disability			
d. Date claimant **will be able to perform usual work****			**

** Even if considerable question exists, ESTIMATE DATE **Avoid the use of terms such as **unknown or undetermined.**

8. In your opinion is this Disability the result of injury arising out of the course of employment or occupational disease? ☐ Yes ☐ No

a. If yes, has Form C-4 been filed with the Workers' Compensation Board? ☐ Yes ☐ No

Remarks: _____

I affirm that I am a:	☐ Chiropractor	☐ Physician	☐ Psychologist	Licensed in the State of:	License Number:
	☐ Dentist	☐ Podiatrist	☐ Nurse-Midwife		

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Health Care Provider's Signature _____ Date _____

Health Care Provider's Name (Please Print) _____ Phone No. _____

Office Address: _____ (Number / Street / Apt/Suite / City or Town / State / Zip Code)

HIPAA NOTICE – In order to adjudicate a workers' compensation claim, WCL 13-8(4) (a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the carrier or employer. Pursuant to 45 CFR 184.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information

INSTRUCTIONS:

1 Claimant completes PART A

2 Health Care Provider completes PART B

KEEP A COPY FOR YOUR RECORDS

3 ***Return to Timekeeping Unit @ your work location***

Timekeeping Unit will return Parts A, B and C to:

NYC Transit Employee Benefits
180 Livingston Street, Room 6008
Brooklyn, NY 11201

Short Term Disability Plan –TWU, Local 100 Represented Employees
Contact List for Administration of Applications

Division	Responsible Unit	Contact Person	Telephone
Department of Subways			
Car Equipment	Central Timekeeping	Robert Mesnard	(718)694-1141
Track	MOW Timekeeping	Beverly Marks	(718)694-4921
Infrastructure	MOW Timekeeping	Beverly Marks	(718)694-4921
Electrical/Signals	MOW Timekeeping	Beverly Marks	(718)694-4921
Electronic Maint.	Controllers Office Central Timekeeping	Gail Williams	(646)252-6526
RTO/Stations	Service Delivery Substation Unit	Isadore Klahr	(718)694-3532
Department of Buses			
Brooklyn Division	East New York Depot Gen. Supt. Support Svc.	Edward Scheid	(718)927-7488
	Flatbush Depot Gen. Supt. Support Svc.	Elizabeth Curry	(347)643-5708
	Fresh Pond Depot Gen. Supt. Support Svc.	Dorothy Spence	(718)334-8605
	Jackie Gleason Depot Gen. Supt. Support Svc.	Richard Dandrea	(347)643-5262
	Ulmer Park Depot Gen. Supt. Support Svc.	Frederick Herman	(718)265-3293
Bronx Division	Gun Hill Depot Gen. Supt. Support Svc.	Robert Trusewicz	(718)430-4833
	Kingsbridge Depot Gen. Supt. Support Svc.	Alberto Richardson	(212)544-3450
	Mother Clara Hale Depot Gen. Supt. Support Svc.	Anthony Maltese	(212)712-5726
	West Farms Depot Gen. Supt. Support Svc.	Elex Myers	(718)319-7572

Short Term Disability Plan –TWU, Local 100 Represented Employees
Contact List for Administration of Applications

Division	Responsible Unit	Contact Person	Telephone
Department of Buses Continued			
Manhattan Division	100th Street Depot Gen. Supt. Support Svc.	Kevin Foster	(212)712-4656
	126th Street Depot Gen. Supt. Support Svc.	Melissa Yard	(212)712-5608
	Manhattanville Depot Gen. Supt. Support Svc.	Matthew Baker	(212)712-4345
	Michael J. Quill Depot Gen. Supt. Support Svc.	Richard Monahan	(212)712-5027
Central Maintenance Facility, 9th Avenue Unit Shop, Crosstown Support Fleet Services.	Director, Administration	Aileen White	(718)927-7921
Zerega Maintenance Facility	Director, Administration	Aileen White	(718)927-7921
General Administrative Services			
Revenue	Director	Joseph Recupero	(348)643-8728
Security	General Superintendent	Ralph Misti	(718)243-4041
Supply Logistics	Director, Financial	Barbara Klein	(347)642-7571
Traffic Checking	General Superintendent	Michael DeMeo	(347)694-1045