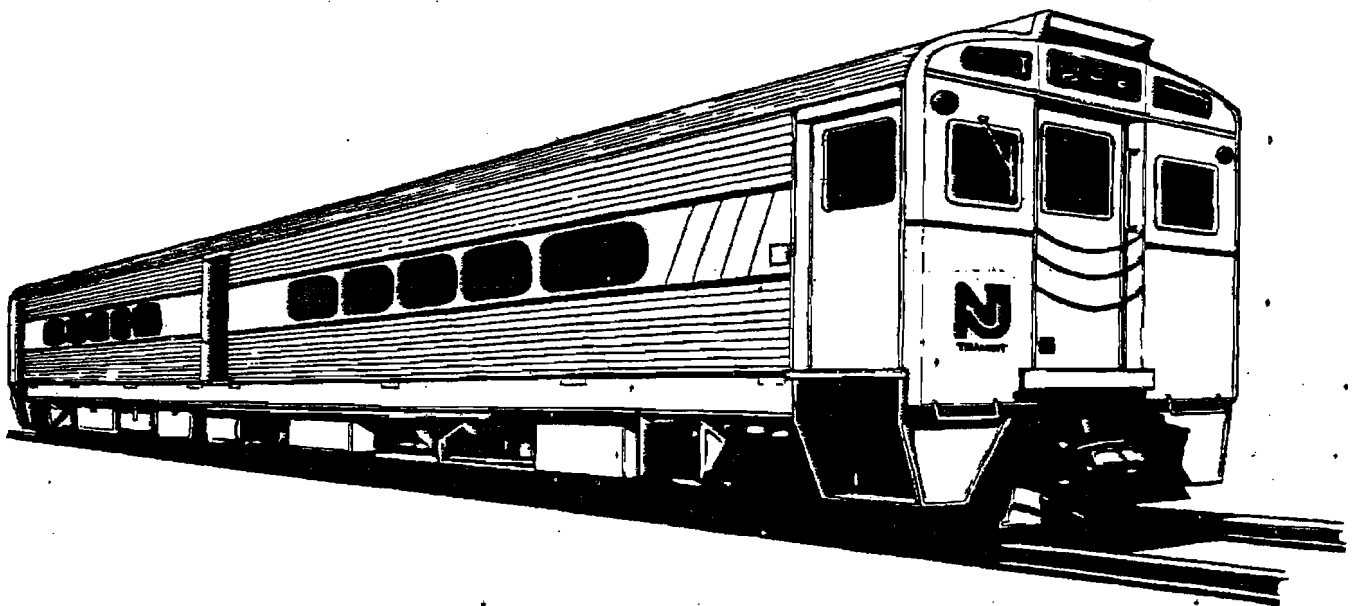


SUPPLEMENTAL SICKNESS  
BENEFIT PLAN

**NJ TRANSIT**  
The Way To Go.



**BLET 171, 272**



*Covering*  
**Brotherhood of Locomotive Engineers**  
July 1, 2000

## FOREWORD

New Jersey Transit Rail Operations, Inc. entered into an agreement effective July 1, 2000 to provide a Supplemental Sickness Benefit Plan for Employees represented by:

Brotherhood of Locomotive Engineers

**BLET 171, 272**

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**SECTION I - SCHEDULE OF BENEFITS**

**Schedule I**

**BENEFITS START: 5th Consecutive Day of Disability**

**MAXIMUM BENEFIT PERIOD: 12 Months**

**BASIC BENEFIT AMOUNT**

For Periods of Disability Starting on or  
After July 1, 2000

<u>Classification</u>	<u>For Covered Employees Who Have Not Received Maximum Sickness Benefits Under RUIA in the Benefit Year Involved</u>		<u>For Covered Employees Who Have Received Maximum Sickness Benefits Under RUIA in the Benefit Year Involved</u>	
	<u>Per Month</u>	<u>Per Day*</u>	<u>Per Month</u>	<u>Per Day*</u>
	Class 1	\$1,466.56	\$48.89	\$2,510.56
Class 2	\$1,015.20	\$33.84	\$2,059.20	\$68.64
Class 3	\$ 902.88	\$30.10	\$1,946.88	\$64.90

← \$40,000

"RUIA" means the Railroad Unemployment Insurance Act. The rate "per day" shown above is the monthly rate divided by 30. It applies to disabilities lasting less than a month or to the extra days for disabilities lasting more than an exact number of months.

**Classification**

You will be classified in accordance with your rate of pay as shown below. The rate of pay;

- (a) includes any differentials regularly paid on the position plus any applicable cost of living allowance and
- (b) is the rate of pay in effect as of July 1, 2000 for the position you last worked prior to becoming disabled.

<u>Classification</u>	<u>Rate of pay as of July 1, 2000</u>
Class 1	\$24.14 or more per hour
Class 2	\$19.80 but less than \$24.14 per hour
Class 3	Less than \$19.80 per hour

The Basic Benefit Amount shown above will be reduced so that it, together with other income benefits, will not exceed the Maximum

**SECTION I - SCHEDULE OF BENEFITS**

Monthly Amount shown on Page 11. Other income benefits include those payable under RUIA and others listed on Page 11.

Important information concerning the relationship between benefits under the Plan and RUIA for persons 65 and over is given on Page 10.

Specific information concerning "Eligibility, Effective Date and Termination of Coverage" is shown in Section II beginning with Page 5.

## SECTION II - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION OF COVERAGE

### Employee Eligibility

Generally speaking, you are eligible for the coverage under this Plan when you become a "Covered Employee". The term "Covered" does not necessarily imply coverage by a contract. The following definitions explain the qualifications for becoming a "Covered Employee".

#### Employee

Employee means an employee who:

- (1) is employed by NJTRO; and
- (2) is represented by the Brotherhood of Locomotive Engineers

In this booklet:

- a personal pronoun in the masculine gender shall include the feminine.
- the Labor Union named in the Foreword may be called the "Union".

#### Qualified Employee

Qualified Employee means an Employee who:

- (1) on the first of the following month after having completed 90 days of continuous employment with NJTRO in a position represented by the Union and covered by its schedule agreement; and
- (2) is a Qualified Employee as that term is defined in Section 3 of the Railroad Unemployment Insurance Act as it now is or may later be amended.\*

\*Section 3 of RUIA effective with base year 1998 states:

"An employee shall be a 'qualified employee' if the Board finds that his compensation will have been not less than \$2,425.00 with respect to the base year, and, if such employee has had no compensation prior to such year, that he will have had compensation with respect to each of not less than five months in such year."

As used above, the term

- "base year" means the calendar year immediately prior to the start of a benefit year.
- "benefit year" means the twelve month period starting on July 1 of any year and ending on June 30 of the next year.

In arriving at the \$2,425.00 only the first \$970.00 of compensation in any month is counted.

## SECTION II - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION OF COVERAGE

### Employee Eligibility

An Employee will become a Qualified Employee on the first day of the calendar month after the above requirements are met.

#### Covered Employee

"Covered Employee" means a Qualified Employee who, under a schedule agreement held by the Union, during any calendar month renders service for pay to NJTRO.

The Qualified Employee will be a Covered Employee only during the calendar month following the calendar month the above requirements are met. Some exceptions appear below.

A new Employee who, after completing the requirements to be a "qualified employee" under RUIA

- becomes disabled while a Covered Employee, and
- continues to be so disabled,

will be eligible for benefits for such disability on the date he becomes eligible to receive RUIA sickness benefits (i.e. July 1 of the next benefit year).

A Covered Employee who ceases to be a Covered Employee due to disability, furlough, leave of absence or discharge will again be a Covered Employee on the date he returns to work provided that the Employee:

- (a) starts work within 12 calendar months after ceasing to be a Covered Employee; and
- (b) works for pay under the coverage of a schedule agreement held by the Union.

Such Employee shall continue to be a Covered Employee for the rest of that calendar month.

A Qualified Employee who has ceased to work for pay may continue to be a Covered Employee if the Railroad:

- (a) is obligated to provide continued benefits under compensation maintenance provisions of an agreement, a statute, or an order of a regulatory authority; and
- (b) makes premium payments in the same manner as if the Employee had worked for pay.

## SECTION II - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION OF COVERAGE

### Employee Eligibility

#### Eligible Employee

"Eligible Employee" means any Covered Employee who becomes eligible for benefits as outlined in SECTION III - COVERAGE PROVISIONS. Benefits under the Plan, however, will not start unless and until the Employee is eligible for and receiving sickness benefits under RUIA.

#### EFFECTIVE DATE

The effective date of the Plan is July 1, 2000.

If you are a Covered Employee, as defined, on July 1, 2000, your coverage will become effective on that date. If you become a Covered Employee after July 1, 2000, your coverage will become effective the date you become a Covered Employee.

#### TERMINATION OF COVERAGE

Your coverage will cease on the sooner of:

- (a) the date the Plan ceases;
- (b) the date the Plan is amended to terminate the coverage with respect to the class of Employees of which you are a member; or
- (c) the date you cease to be a Covered Employee as defined on Page 6.

## SECTION III - COVERAGE PROVISIONS

### Benefits Payable

Benefits will be paid to you if you become Totally Disabled due accident or sickness subject to the following:

- (1) The Period of Disability must start on or after July 1, 2000 and while you are a covered Employee.
- (2) Benefits are subject to all the terms, conditions, limitations and exclusions of the Plan.
- (3) Benefits start on the 5th consecutive day of disability.
- (4) You must be certified Totally Disabled by a legally qualified physician.
- (5) Benefits will be paid monthly while a Period of Disability continues. Benefits will end on the sooner of:
  - (a) the date of your death;
  - (b) the date your total disability ceases; or
  - (c) the date you have become entitled to benefits for 12 months, subject to item (j) under Limitations and Exclusions on Page 13.

"Totally Disabled" means that due to an accident or sickness:

- (1) you are receiving care by a legally qualified physician which is appropriate for the nature of the condition. (We will waive this requirement when continued care would be of no benefit to you); and
- (2) you are unable to perform the duties of any job available to you in your craft; or
- (3) you are unable to perform the duties of the last job on which you worked before your disability began, if there is no job available to you in your craft.

"Period of Disability" means a period of time during which you are Totally Disabled from one or more causes. It starts the first full day Total Disability after you cease active work for NJTRO. The Period Total Disability ends on the sooner of:

- (1) the date you cease to be Totally Disabled; or
- (2) the date you go back to active work for any employer.

### SECTION III - COVERAGE PROVISIONS

#### Benefits Payable (Continued)

Successive Periods of Disability, regardless of whether or not the disability started while you were a covered Employee, will be considered one Period of Disability unless the later period:

- (1) is separated by a period of 90 consecutive calendar days during which you have worked on a full time basis; or
- (2) is due to an entirely unrelated cause and begins after you have returned to active work on a full time basis for at least one day.

"Time of day", when used in connection with this Plan means the local time used in operations by NJTRO at the place where the event occurs.

### SECTION III - COVERAGE PROVISIONS1/

#### Basic Benefit Amount

The amount of monthly benefit is the "Basic Benefit Amount" reduced by the "Reductions Applicable to Basic Benefit Amount" shown on Page 11. The Basic Benefit Amount is determined in accordance with "Part I - Basic Benefit Amount" below.

#### Part I-Basic Benefit Amount

The Basic Benefit Amounts shown in SECTION I - SCHEDULE O BENEFITS are payable with respect to periods of disability commencing on or after July 1, 2000, subject to the following:

1. The benefit rate will not change to the increased amount during any period of disability unless the covered Employee exhausts his sickness benefits under RUIA. Likewise, if during any period of disability a new benefit year under RUIA starts and if the covered Employee whose sickness benefits had been exhausted is again qualified for such benefits, the benefit rate under this Plan will be changed to the reduced amount.
2. If during any period of disability a new benefit year under RUIA starts and the covered Employee whose benefits had been exhausted is not qualified and eligible to again receive sickness benefits under RUIA, the benefits under this Plan will nevertheless be payable, but at the reduced amount.

In determining the Basic Benefit Amount, if you are a Covered Employee age 65 or over you will be considered to be eligible to receive extended or accelerated sickness benefits under RUIA if you would have been eligible to receive such benefits if you had been under 65 years of age. Likewise, if you are a Covered Employee age 65 or over you will not be considered to have received the maximum sickness benefits payable under RUIA if you would have been eligible to receive extended or accelerated benefits if you had been under 65 years of age. If RUIA is amended to increase the amount of sickness benefit payable, so that the sum of

- (a) 21.75 times the average daily sickness benefits for your class under RUIA, plus
- (b) the Basic Benefit Amount provided for you while receiving sickness benefits under RUIA;

exceed the maximum monthly amount shown below for your class, your Basic Benefit Amount will be reduced by an amount equal to the amount by which (a) plus (b) exceeds the Maximum Monthly Amount for your class.

### SECTION III - COVERAGE PROVISIONS

#### Basic Benefit Amount (Continued)

<u>Classification</u>	<u>Maximum Monthly Amount</u>
Class 1	\$2,510.56
Class 2	\$2,059.20
Class 3	\$1,946.88

The Basic Benefit Amount payable under this Plan will be reduced to the extent that it together with RUIA benefits and other Income benefits shown in Part II exceed the Maximum Monthly Amount.

#### Part 2-Reductions Applicable to Basic Benefit Amount

- A. If you are entitled to benefits under this Plan and receive any of the payments in (1), (2), (3) or (4) below for any part of the same period of time, your Basic Benefit Amount will be reduced. The Basic Benefit Amount will be reduced by the amount that the sum of
- (a) your Basic Benefit Amount; plus
  - (b) other payments described in (1), (2), (3) or (4); plus
  - (c) sickness benefits payable under RUIA; exceed the Maximum Monthly Amount for your class as shown on this page. Other payments include:
    - (1) annuity payments under the Railroad Retirement Act;
    - (2) benefit payments under Title II of the Federal Social Security Act;
    - (3) unemployment, maternity or sickness benefits under any unemployment, maternity or sickness compensation law other than RUIA; and
  - (4) any other social insurance payments under any law.

If you do not receive sickness benefits under RUIA because of the provisions of Section 4 (a-1) (ii) of such Act\*, the Basic Benefit Amount, reduced as provided above, will be paid. Item (k) under Limitations and Exclusions on Page 11 will not affect this provision.

\*Section 4(a-1) (ii) of RUIA provides that you will be disqualified for benefits for any day for which you receive unemployment, maternity, or sickness payments under another law. If you receive payments as described in (1), (2), or (4) of Paragraph A, they will be offset against your payments under RUIA.

### SECTION III - COVERAGE PROVISIONS

#### Basic Benefit Amount (Continued)

If you receive any payments described in (1), (2), (3), or (4) retroactively for a period for which benefits were paid under this Plan, Provident may recover any excess benefits it has paid. The amount recovered will be the excess of the amount Provident would have paid had the retroactive payments been made at the time this Plan's benefits were paid.

- B. If you are eligible for benefits for a disability under any other plan, fund or other arrangement by any name for which an employer has contributed, the Basic Benefit Amount will be reduced so that the sum of
- (a) the benefits described above; plus
  - (b) your sickness benefits under RUIA; plus
  - (c) the Basic Benefit Amount;
- will not exceed the Maximum Monthly Benefit Amount for your class as shown on Page 11. A plan, fund, or other arrangement includes but is not limited to:
- (i) any group life policy providing installment payments for permanent total disability;
  - (ii) any group annuity contract;
  - (iii) any pension or retirement annuity plan; or
  - (iv) any group accident and health insurance paying loss for time benefits for disability.
- C. If you are disabled in an off-track vehicle accident covered under Article IV of the National Agreements of September 20, 1968, or similar provisions, the Basic Benefit Amount will be reduced by the amount of any payment made to you for time loss for the same disability.

### SECTION III - COVERAGE PROVISIONS

#### Limitations and Exclusions

No payment will be made for disability:

- (a) for the first four consecutive days of any Period of Disability;
- (b) for more than 12 months during any Period of Total Disability, subject to item (j) below;
- (c) for any period during which you are not certified Totally Disabled by a legally qualified physician or surgeon;
- (d) for any day you work at any gainful occupation;
- (e) which begins after you have started work on a regular or permanent basis for NJTRO other than on a position coming under a schedule agreement held by the Union unless the last position on which you worked before the start of your disability was a covered position;
- (f) due to intentionally self-inflicted injury or sickness;
- (g) when your commission or attempted commission of a felony was a contributing cause;
- (h) due to war or act of war (whether war is declared or not), insurrection or rebellion, or your participation in a riot or civil commotion;
- (i) starting after your employment with NJTRO has ended.
- (j) for any period for which you receive vacation pay during a disability. (This Plan's disability benefit period will be extended beyond 12 months by the number of days for which benefits are denied because of vacation pay); or
- (k) for any period for which you are eligible to receive disability benefits under RUIA but are denied benefits for any reason including your failure to apply.

### SECTION III - COVERAGE PROVISIONS

#### Claim Payments

#### Notice of Claim

Written notice of any injury or sickness must be given within 20 days the start of disability or as soon as reasonably possible. The Notice must be given to Provident with information sufficient to identify you as covered Employee. A Notice of Disability form is included in the booklet. It may be used to report a claim under this Plan.

#### Claim Forms

When notice of claim is received, Provident will provide claim forms for the filing of proofs of loss. If such forms are not sent within 15 days, you will have met the proof of loss requirement if you give the Provident written statement of the nature and extent of the loss within the time fixed in this Plan.

#### Proofs of Loss

Written proof must be given to the Provident within 90 days after the start of any period of disability for which benefits are claimed under the Plan. However, a claim will still be considered if it was not possible to furnish proof within this time and the proof was furnished as soon as possible. The proof must show that you have applied, and have furnished proofs when asked, for all disability benefits.

#### Time of Payment of Claims

Subject to written proof of total disability, all accrued benefits will be paid monthly. Any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

#### Payment of Claims

All benefits will be paid to you, if living, otherwise to your estate.

If benefits are payable:

- to your estate; or
- to a person who cannot give a valid release;

Provident can pay up to \$1,000 to someone related to you by blood or marriage who Provident believes has a right to it. Provident will be discharged to the extent of any such payment made in good faith.

#### Physical Examination

The Provident will have the right to examine you as often as it may reasonably require while a claim is pending. This will be at the expense of the Provident.

### **SECTION III - COVERAGE PROVISIONS**

#### **Claim Payments (Continued)**

##### **Legal Actions**

No action can be brought to recover under the Plan until 60 days after proof of disability has been given. No action can be brought after 3 years from the date such written proof is required.

##### **Choice of Physician**

You will have free choice of any physician practicing legally. The Provident will not in any way disturb the physician-patient relationship.

### **GENERAL PROVISIONS**

##### **Conformity With State Statutes**

Any provision of the Plan which, on its effective date, is in conflict with the laws of the state in which you reside on that date is changed to conform with the minimum requirements of those laws.

##### **Workers' Compensation Not Affected**

This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation Insurance.

## ADDITIONAL INFORMATION

### Federal Tax Information

Federal Law requires that benefit payments under this Plan be reported to the Internal Revenue Service. You will be furnished with a W-2 Form showing the amount of benefits, if any, you are paid each year.

Federal Law also requires that Railroad Retirement Tier I Taxes be withheld from Plan payments made during the first six (6) months following the month of disability. Your employer is required to pay a matching share of the Railroad Retirement Tax withheld.

### On Duty Injuries

This Plan has been issued in fulfillment of certain collective bargaining agreements. The agreements contain the following provision:

"In case of a disability for which the employee may have a right of recovery against the employing railroad, benefits will be paid under this Plan pending final resolution of the matter so that the employee will not be exclusively dependent upon his sickness benefits under the Railroad Unemployment Insurance Act. However, the parties hereto do not intend that benefits under this Plan will duplicate, in whole or in part, any amount recovered for loss of wages from the employing railroad, and they intend that benefits paid under this Plan will satisfy any right of recovery for loss of wages against the employing railroad to the extent of the benefits so paid. Accordingly, benefits paid under this Plan will be offset against any right of recovery for loss of wages the employee may have against the employing railroad;....."

Thus, to the extent benefits are paid under this Plan, such benefit payments shall be deducted from any recovery for loss of wages in any case in which the employer is liable for the injury.

### HOW TO FILE A CLAIM

- (1) Complete the "Notice of Disability" Form F-602086 and send it to Provident. Do this as soon as you know your disability will extend beyond four consecutive days.
- (2) Have your doctor complete the "Proof of Disability" Form F-68651 at the end of the first thirty (30) days of disability or at the end of the disability, whichever comes first.
- (3) Address all correspondence to:

**Provident Life and Accident Insurance Company**  
**Railroad Disability Claims**  
**P. O. Box 180135**  
**Chattanooga, TN 37401-7135**

To speed up your claim, the Notice of Disability and Proof of Disability forms may be either mailed or faxed. Each form has been pre-printed with the correct address for mailing.

If you prefer to fax, the number is 423-755-7857.

- (4) You should also obtain and fill in the U.S. RAILROAD RETIREMENT BOARD "Application for Sickness Benefits" form. Have your doctor fill in the RAILROAD RETIREMENT BOARD "Statement of Sickness" form. Promptly mail both forms to Bureau of Employment and Sickness Insurance, U.S. Railroad Retirement Board, 844 Rush Street, Chicago, Illinois, 60611.

After the "Notice of Disability" form is received, Provident will acquire certification from your employer and the Railroad Retirement Board.

It is important that the "Notice of Disability" form be sent promptly so that certifications can be obtained. This will enable Provident to pay your claim immediately when proof of your disability is received.

If you have any questions about filing your claim, please call 1-800-542 4231.

ASO 4774



UNUM.

Provident Life and Accident Insurance Company
P.O. Box 180135, Chattanooga, TN 37401-7135

NOTICE OF DISABILITY
SUPPLEMENTAL SICKNESS BENEFIT PLAN
New Jersey Transit, Policy R-800

IN CASE OF CLAIM YOU SHOULD FULLY COMPLETE THIS FORM IMMEDIATELY,
AND MAIL TO PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY.

RAILROAD DISABILITY CLAIMS

Customer Service Telephone No.: 1-800-542-4231 • Fax: 423-755-7857

SECTION I. This section must be completed by or in behalf of the Employee for all claims.

Name of Employee (Please Print) Date of Birth Social Security No. Employee No.
Employee's Address (Number) (Street) (City) (State) (Zip) Telephone Number Date Employed

Division or Department Last Worked. Indicate which Organization represents you:
Boilermaker, etc. Firemen & Oilers Sheet Metal Workers UTU
BLE Machinists Signalmen Yardmasters
Electricians Maintenance of Way TWU/Carmen Other

Date You Last Worked Rate of Pay (per hr./per mo.) Location Last Worked

Occupation When did you become disabled A.M. P.M. Indicate Cause of Disability
Date Time Accident (Complete Part II)
Sickness (show cause)

Name of your Doctor Date of First Treatment Have you returned to work?
Yes - If so, give date

Have you completed a total of at least 12 calendar months of employment with one or
more participating railroads? Why did you stop working (check one)
Disability Retired Leave of Absence
Did you work for the Employer named above (or take vacation with pay)
Furlough Discharged Resigned
in the month before you became disabled? Other (explain)

SECTION II. To be completed only if accident involved.

Date of Accident Time A.M. P.M. Were you at work when accident happened? Yes No
If so for whom?

Explain how Accident happened

Was a railroad off-track vehicle involved? Yes No Did Injury result from a Traffic Accident Yes No Will a Liability Claim be made? Yes No

SECTION III. This section must be completed and signed by or in behalf of the employee for all claims.

Benefits under the Railroad Unemployment Insurance Act:
1. Have you applied for sickness benefits under the Railroad Unemployment Insurance Act? Yes No
2. If not, why not?
Am not qualified under the Act.
My benefits have been exhausted for this benefit year.
Other (explain)

Other Income Benefits:
Are any of the "Other Income Benefits" listed below available to you while disabled? Yes No (If yes, check each of the following which is
applicable, and show monthly amounts payable).
Railroad Retirement Act - Disability Annuity \$
Social Security Act \$
Military Pension \$
Wage Continuation \$
Workmen's Compensation \$
Protective Agreement \$
Advancement from possible settlement with Railroad \$
Any other plan toward the cost of which any employer has contributed (Specify) \$

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false
information, or conceals for the purpose of misleading; information concerning any fact material thereto, commits a fraudulent insurance act which is a
crime, in Florida, a felony of the third degree.

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


Signature of Employee Date

Do you have a medical form for your doctor to complete at the end of your disability, or at the end of the first 30 day period of disability? Yes No

**PART A - HEALTH INSURANCE CLAIM - GROUP POLICY 800**
**IMPORTANT INSTRUCTIONS**

In case of claim for disability, notify Company immediately by completing a "NOTICE OF DISABILITY". This blank is to be completed as proof of your claim at the end of the first thirty days of disability or at the end of disability if you are not off from work that long.

**FOR PROMPT PAYMENT OF YOUR CLAIM**

1. Fully complete information to the right. 
2. Have attending physician complete Part B below.
3. Mail completed form to the address shown at the bottom of this form.

**TO BE COMPLETED BY PATIENT (EMPLOYEE)**

Name of Employee (Please Print)			Date of Birth
Employee's Address (Number and Street)			
City	State	Zip	Occupation
NEW JERSEY TRANSIT RAIL OPERATIONS			
Name of Employee			Social Security No.
Have you received vacation pay since your disability commenced?			
<input type="radio"/> Yes <input type="radio"/> No   If so, show dates for which you received vacation pay.			
From _____		To _____	
Date		Date	

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act which is a crime, in Florida, a felony of the third degree.

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

**AUTHORIZATION**

Solely to assist Provident Life and Accident Insurance Company in administering an insurance claim, I hereby authorize any provider of health care including but not limited to any institution, or person possessing information concerning:

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

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

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

Signature \_\_\_\_\_ Date \_\_\_\_\_

Special for Typewriter - Mark for Tabulator Appear on this Line

**PART B - ATTENDING PHYSICIAN'S STATEMENT**

1. Diagnosis and concurrent conditions (If diagnosis code other than ICDA\* used, give name)

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

5. Is patient receiving physical therapy?    Yes    No   If "Yes," indicate name and address of Facility

6. Date symptoms first appeared or accident happened.

7. Date patient first consulted you for this condition.

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

9. Patient still under your care for this condition?    Yes    No

10. Patient was continuously totally disabled (Unable to work)

From \_\_\_\_\_ To \_\_\_\_\_

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

Date \_\_\_\_\_ Physician's Name (Print) \_\_\_\_\_ Signature \_\_\_\_\_ Degree \_\_\_\_\_ Insurer's Account No. \_\_\_\_\_