
Welcoming Home a New Baby
Trasnit Guide to your
Rights and Forms
MEMBER DRIVEN • MEMBER BUILT • MEMBER STRONG
TRANSPORT WORKERS
AFL CIO
UNION
LOCAL 100

Congratulations!!!!!!!!

Bringing a new baby into your home may feel daunting at times, but please know that you have support every step of the way. TWU Local 100 is here to assist you with all your entitled rights, necessary forms, and contacts. Rest assured, you're not alone—we're genuinely here for you with full support and care. Below, you will find all the information you need, including whom to contact and when, ensuring you have everything necessary for this new journey.

- Reasonable Attached Accommodations
- Maternity/Paternity Leave
- FMLA
- Sick Leave/60 % Sick leave
- NYS Short Term Disability
- Disability Insurance
- Leave of Absence
- TWU Newborn Stipend

Reasonable Accommodation(s)

If you are an expecting Train Operator or Conductor and need a reasonable accommodation you will have to apply, the basic process is to complete Page 1 “Exhibit A” of the application form, obtain a note from your doctor, and submit the documents. You will also have to undergo a MAC assessment, and interview for the position. Currently the reasonable accommodations are Platform (Conductors), Switching (T/O) or Dedicated Announcer (10 rotating spots for both titles). Forms attached.

Maternity/Paternity Leave

As Per the 2023-2026 MOU New York City Transit employees are entitled 12(4 weeks company paid, additional 8 weeks for birth mothers full pay at run pay). It is used by calling the Crew Office and letting them know you want to take your maternity/paternity leave. The Leave of Absence (Other than Sick) application form must be filled out no later than 3 days after the leave has started. Initial documentation (discharge/letter from hospital) must be submitted with the application form. Final Documentation (birth certificate) must be submitted no later than 30 working days after returning from Maternity/Paternity leave. Parent’s name MUST be on the birth certificate. All forms can be sent over to the Cheung Taking in the DIF/MAPA unit email is SubwaysMAPA@nyct.com phone # 718-694-3043.

FMLA

FMLA is usually taken after the MAPA leave but should be given in advance as at minimum it takes up 30 days for approval. FMLA forms are available on the BSC. You will need the HR-BEN-028, HR-BEN-069 & HR-BEN-070. If you have any questions about the forms or FMLA itself, contact the FMLA Unit at 718-694-4593 or email them at subwaysfmla@nyct.com

Sick Leave/60 % Sick leave

After the exhaustion of your FMLA if you still need additional time, you must notify the Crew Office you will be resuming from FMLA and going out sick further notice. As with being out sick at any time after you will need to submit sick forms with doctor lines to cover you from the first date of absence to when you return. If you have more than 4 years of service with NYCT, you become eligible for 60 % sick leave (Section 2.6 Q Sick Leave).

Years of Service	Eligible Days
4 or less	0
4-8	15
8-14	30
14-20	60
20+	90

* To be eligible to receive the additional days of sick leave on a sixty percent (60%) you must have been eligible for the allowance of the 12 sick days.

Leave of Absence

If more time is needed, you can request a leave of absence without pay (Section 2.11- leaves of absence without pay) by contacting the crew office on the length of time needed. You will need a G2 with the reasons and attach "an Other Than Sick Leave" application. Additional documentation may also be required. It is subject to approval of the crew office for 14 days or less. Anything more than 14 days will be subject to approval of the Chief Transportation officer. ***In addition to these things there are also some other programs you can apply for and should be entitled to from the union and other entities.***

NYS Short Term Disability

This is applied for AFTER the exhaustion of your sick time and 60% sick*. Pays up to a max of $170 week for 26 weeks. You can drop the forms off to the Disability Unit located at 130 Livingston Street on the 6th floor. You can also send them in via email (subwaysdisabilityforms@nyct.com) or fax (718-694-5971). If you email them include name, title, and pass. If any questions you can call 718-694-4282.

Disability Insurance

If you have the off the job disability insurance, you can also file a claim. You typically must be out a minimum amount of time, fill out the paperwork and either drop it off or send it in. If dropping it off in person, they go to the Disability Unit located at 130 Livingston Street on the 6th floor. You can also send them in via email (subwaysdisabilityforms@nyct.com) or fax (718-694-5971). If you email them include name, title, and pass. If any questions you can call 718-694-4282.

TWU Newborn stipend

To qualify you must be in Good Standing and be out of work unpaid with no leave balances (AVA, Vacation, Sick, & PLD). The benefit is $300 a week up to 4 weeks. You do not need to pass probation to apply. You can contact the Childcare Fund (CCF) for more information.
Phone: 718-870-8700, or Email: childcarefund@twulocal100ccf.org

TWU Local 100 Working Women's Committee

During your pregnancy or any time after you can always reach out the Working Women's Committee for guidance or assistance as well. When returning to work and in need of lactating assistance please reach out to the program's Director **Giselle Martinez** as she can help you get set up to do so. You can utilize the link below to find out more about them and how to get involved.

Giselle Martinez
Director| Family & Women's Assistance |Transport Workers Union, Local 100
195 Montague Street, Brooklyn NY 11201
Office: 212.873.6000 x2272 | | **Fax:** 347.916.0578
Email: gmartinez@twulocal100.org http://www.twulocal100.org/working-womens-committee

RAPID TRANSIT OPERATIONS
Denise Long Phone # 929-276-2137; email: Dlong@twulocal100.org
Nivea Luke Phone # 347-509-6124; Email: nluke@twulocal100.org
Cristina Hernandez # (914) 999-2044; Email: CHernadez@twulocal100.org
Kristian Magwood Phone #718-845-3680 Email: kmagwood@twulocal100.org

Exhibit A

(To be completed by employee/applicant and returned to Human Resources or *DRA*)

Name	BSC ID #:	Job Title (if different)
Office/Unit	Work Location	Telephone Number(s)
E-mail address:	Preferred method of communication:	

ALL REQUESTS: Please identify the accommodation you are requesting and the reasons for your request.
CURRENT MTA EMPLOYEES: What aspects of your job will this accommodation assist you with? Which job duties specifically do you require an accommodation to reasonably perform?

You must also submit supporting medical documentation from your personal physician to: [AGENCY OCCUPATIONAL HEALTH SERVICES]

Occupational Health Services can be reached at any of the following phone numbers: [AGENCY OCCUPATIONAL HEALTH SERVICES CONTACT INFO]

Employee Signature	Date

The employee should retain a copy of this form. The original is filed by the *DRA*.

To be completed by the HEALTHCARE PROVIDER

Instructions to the Physician:

Your patient, the employee/applicant listed above, has requested a reasonable accommodation for a disability or pregnancy-related condition. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a physical or mental impairment, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine eligibility for a reasonable accommodation.

Provider Name (please print):	
License Number:	**State:**
Type of Practice/ Medical Specialty:	
Business Address:	
Phone Number:	**Fax Number:**

1. **Based on your conversation with the patient, please list your understanding of the essential functions of the patient's job.**

2. **Does the patient have a physical or mental impairment? Yes _____ No _____**

3. **Please describe the patient's physical or mental impairment, not just the diagnosis.**

4. **When did the physical or mental impairment begin?**

5. **How long is the physical or mental impairment expected to last?**

To be completed by the HEALTHCARE PROVIDER (Continued)

6. **Please describe the major life activities (e.g., breathing, eating, sleeping, walking, talking, manual tasks, etc.) that are substantially limited by the patient's physical or mental impairment or accompanying treatment.**

7. **What limitations caused by the physical or mental impairment affect the patient's ability to reasonably perform the essential functions of their job?**

8. **What adjustments to the work environment, work schedule or job responsibilities would enable the patient to reasonably perform the essential functions of their job?**

9. **How long will the patient need the reasonable accommodation? If unable to provide date, when will they be medically reevaluated?**

10. **Additional Comments or Suggestions:**

I do hereby certify that to the best of my knowledge the above information is true and correct. **Healthcare Provider Signature: _____ Date: _____**

PHYSICIAN STAMP

NOTICE

NOTICE NO.: 55-23 (Supersedes Notice No.: 78-14) August 8, 2023

TO: ALL TWU-LOCAL 100 HOURLY EMPLOYEES

SUBJECT: **TWU-LOCAL 100 MATERNITY / PATERNITY LEAVE BENEFIT**

Effective July 19, 2023, employees who are members of TWU-Local 100 are now entitled to a four (4) week paid Maternity/Paternity Leave benefit.

In addition to the four (4) weeks paid Maternity/Paternity Leave, birth mothers are entitled to paid Recovery Leave for the first eight (8) weeks following the birth of the child(ren), which shall occur prior to Maternity/Paternity Leave.

- Four (4) weeks paid Maternity/Paternity Leave benefit is only effective for births or adoptions that occur on or after July 19, 2023.
- Eight (8) weeks paid Recovery Leave for birth mothers is only effective for births that occur on or after July 19, 2023.
- Maternity/Paternity leave is effective upon the birth or adoption of a child.
- Employees are entitled to four (4) weeks fully paid Maternity/Paternity Leave.
- Maternity/Paternity Leave is treated as a 20-day continuous paid absence immediately following the birth or adoption of a child.
- Both parents, if they are TWU-Local 100 members, are entitled to this leave.
- Employees are required to give proper notice, by telephone, to their respective Crew Assignment Section of their intention to be absent from work due to Maternity/Paternity Leave.

Employees are required to complete the attached *Application of Leave* and submit with appropriate documentation to:

Email: SubwaysMAPA@nyct.com
Phone: (718) 694-3043
Inter-office/USPS Mail Cheang Taing, 130 Livingston Street, 6th Floor Brooklyn, NY 11201

The *Application of Leave* form must be submitted with the initial documents* (i.e., discharge papers/letter from hospital) no later than three (3) days after the absence start date. Final documentation (i.e., Birth Certificate) must be submitted no later than thirty (30) working days after the employee returns from Maternity/Paternity Leave.

For Paul J. McPhee
Chief Officer, Field Operations
Service Delivery
"EVERY SECOND COUNTS"

Attachment
NOTICE NO.: 55-23 (Supersedes Notice No.: 78-14)

MTA New York City Transit

112_16

MTA New York City Transit

Manhattan & Bronx Surface Transit Operating Authority

REQUEST FOR LEAVE OF ABSENCE WITH OR WITHOUT PAY (OTHER THAN SICK LEAVE)

Department SUBWAYS Division RTO Date 20

I _____, hereby request a leave of absence
Print or Type Name – First M I Last

From duty with/without pay in accordance with established procedures (TA Rule no. 170) TWU Local 100 MOU 2023
(Check or Insert Proper Rule No.)

From _____ to _____, inclusive, being

40 Days @RUN PAY hours. Reporting point _____ Days off _____

Run or trick No. _____ Scheduled hours of work _____ A.M. P.M. _____ A.M. P.M.

Reason for absence RECOVERY LEAVE

Employee Signature _____

Title (Print or Type) _____ **Pass or Payroll No.** _____ **Rate of Pay** _____

Supervisor Signature _____ **Pass Number** _____

Do not write in this space

Original Date of Appointment with NYCTA, MaBSTOA or Predecessor _____

Absence with Pay During Preceding 12 Months	Days	Hours	Absence With Pay During Preceding 12 Months	Days	Hours
Vacation			Absence Without Leave		
Holiday Allowance			Personal Business		
Injury On Duty			Illness		
Sick Leave					
Other Causes					
Total			Total		

Payroll No. _____

Remarks _____

Recommendation: For _____ Days _____ Hours

Signatures (As per procedure in effect) _____, _____ Title, _____ 20__

_____, _____ Title, _____ 20__

_____, _____ Title, _____ 20__

_____, _____ Title, _____ 20__

Leave of Absence
Approved ☐ Disapproved ☐ _____, _____ Title, _____ 20__

Remarks: **RTO CREW ASSIGNMENT OFFICIAL DATE AND TIME: 11/18/2008 10:12:45 AM**

ORIGINAL to PERSONNEL DIRECTOR

MTA New York City Transit

Manhattan & Bronx Surface Transit Operating Authority

REQUEST FOR LEAVE OF ABSENCE WITH OR WITHOUT PAY (OTHER THAN SICK LEAVE)

Department Subways Division _____ Date _____ 20____

I _____, hereby request a leave of absence
Print or Type Name – First M I Last

From duty with/without pay in accordance with established procedures (TA Rule no. 170) _____
(Check or Insert Proper Rule No.)

From _____ to _____, inclusive, being

_____ Days _____ hours. Reporting point _____ Days off _____

Run or trick No. _____ Scheduled hours of work _____ A.M. P.M. _____ A.M. P.M.

Reason for absence Maternity / Paternity Leave

Employee Signature _____

Title (Print or Type) **Pass or Payroll No.** **Rate of Pay**

Supervisor Signature _____ **Pass Number** _____

Do not write in this space

Original Date of Appointment with NYCTA, MaBSTOA or Predecessor _____

Absence with Pay During Preceding 12 Months	Days	Hours	Absence With Pay During Preceding 12 Months	Days	Hours
Vacation			Absence Without Leave		
Holiday Allowance			Personal Business		
Injury On Duty			Illness		
Sick Leave					
Other Causes					
Total			Total		

Payroll No. _____

Remarks _____

Recommendation: For _____ Days _____ Hours

Signatures (As per procedure in effect) _____, _____, _____ 20____
Title

_____, _____, _____ 20____
Title

_____, _____, _____ 20____
Title

_____, _____, _____ 20____
Title

Leave of Absence
Approved ☐ Disapproved ☐ _____, _____, _____ 20____
Title

Please submit the following initial documentation with this request as applicable:

Spouse: Marriage Certificate and Discharge Papers or Letter from Physician

Single: Copy of Proof of Paternity document or Hospital Discharge Papers **(name of father must be on document)**

Mothers: Hospital Discharge documents or document from Midwife or Letter on Physician's Letterhead

FINAL PROOF - A Copy of the newborn's BIRTH CERTIFICATE within 30 Days of Employee's Return to Work

FMLA

FAMILY & MEDICAL LEAVE ACT

The New RTO
Knowledge Is Power

IMPORTANT STUFF TO KNOW

FMLA is a federal Law passed in 1993 that requires employers to grant employees up to 60 days of unpaid leave from your job per year.

YOU QUALIFY IF ...

- You have worked for Transit for at least 12 months and,
- You have worked for 1250 hours in the 12 months before the start of your FMLA leave

AND YOU NEED TO ...

- Be treated for, or recover from, a serious health condition that makes you unable to perform your job - (medical leave) **Note:** You can use sick leave or vacation leave prior to taking FMLA.
- Care for a child, spouse or parent suffering from a serious health condition (family-care leave)
- Care for or bond with a new born child, a newly adopted son or daughter, or a newly placed foster child (new-child leave) **Note:** You cannot use your sick leave for a new-born.

OR, YOU NEED TO:

- Meet an urgent non-medical need brought on by a family member serving in the military or being notified of impending call to duty
- Take up to 26 weeks of leave to care for a family member who suffers an injury or illness while serving in the military

A chronic condition is a medical condition which continues over a long period, requires treatment by a healthcare provider at least two times per year and may cause short periods of incapacity from time to time instead of one long period. Some examples are: heel spurs, back pain, migraines, asthma, allergies, HIV, chemotherapy, sinusitis. You can take intermittent leave (absences at various times) for these conditions under FMLA

Get Your Forms Here

The TA MUST KEEP FMLA RECORDS CONFIDENTIAL.
Only the designated coordinator and OHS have access.

Family and Medical Leave Act Request Form

HR-BEN-028

Section 1 - Information and Instructions

The purpose of this form is to request a leave of absence under the Family and Medical Leave Act (FMLA).

DO NOT COMPLETE THIS FORM IF YOU HAVE APPLIED ONLINE

TO APPLY ONLINE:

1) Sign on to My MTA Portal – www.mymta.info
2) Click the My Benefits Ribbon
3) Click the FMLA Request Link
4) Be sure to click the icons next to the link to access essential information.

TO USE THIS FORM:

If you are unable to apply online, complete this form and submit as follows, 30 days prior to the start of your leave or as soon as possible:

- MTA Agencies: Mail, email. or fax to your Agency Human Resources Department.
- MTAHQ and BSC Employees: Email or fax to the BSC at fax# 212-852-8700 or bscservice@mtabsc.org

DOCUMENTATION REQUIRED FOR ONLINE AND PAPER FORM REQUESTS:

If your request for FMLA is for you or a family member with a serious health condition, a medical certification is required. Visit My MTA Portal, www.mymta.info to download the applicable FMLA application and medical certification:

a) HR-BEN-069 FMLA Certification of Health Care Provider Employee's Serious Health Condition

b) HR-BEN-070 FMLA Certification of Health Care Provider Family Member's Serious Health Condition

c) HR-BEN-071 FMLA Certification of Qualifying Exigency for Military Family Leave

d) HR-BEN-072 FMLA Certification for Serious Injury or Illness of Covered Service Member

EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT:

The FMLA provides eligible employees with up to 12 weeks of unpaid leave for the following reasons: (1) incapacity due to pregnancy, prenatal medical care or childbirth; (2) to care for a child after birth, or placement for adoption or foster care; (3) to care for a spouse, child, or parent who has a serious health condition; (4) for the employee's own serious health condition that makes them unable to perform their job; and (5) to address certain qualifying exigencies if a spouse, child or parent is on active duty or called to active duty in a foreign country. The FMLA also provides up to 26 weeks of leave to care for a covered service member who has a serious illness or injury under certain circumstances.

The complete Employee Rights document can be downloaded from My MTA Portal, www.mymta.info or obtained from your manager or the MTA Business Service Center at 646-376-0123.

If you have any questions about FMLA leave, please contact your agency Human Resources Department.

Section 2 - Employee Information

Print Name	Last	First	M.I.	Suffix		BSC ID
						Agency ID
Agency/ Dept (check one)	☐ BSC	☐ B&T	☐ CC	☐ HQ	☐ Police	Department
	☐ SIR	☐ LIRR	☐ MNR	☐ MTA Bus	☐ NYCT	Job Title
					☐ MaBSTOA	Reg Work Sched
Street Address						
City					State	Zip Code
Phone (H)		Phone (W)				Email

Family and Medical Leave Act Request Form

HR-BEN-028

Section 3 – Reason for Leave	
Please Check only one:	
My own serious health condition or pregnancy renders me unable to perform the functions of my position.	
The birth and/or care of a child within 12 months of date of birth. (Provide verification of Date of Birth)	
The placement with me of a child for adoption or foster care, or to care for a child	
To care for my ☐ spouse ☐ child ☐ parent with a serious health condition. (Birthdate of Care Recipient:).	
Qualified exigency leave for my ☐ spouse, ☐ child, or ☐ parent on active duty or called to active duty in a foreign county	
To care for my ☐ spouse, ☐ child, ☐ parent, or ☐ next of kin who is a covered service member with a serious injury or illness, or ☐ for my pregnant spouse.	

Section 4 – Request for Leave	
Leave Start Date	Leave End Date

Section 5 – Type of Leave Requested
a) State the type of leave you are requesting: ☐ Intermittent | Reduced Schedule | Continuous (Intermittent Leave is separate blocks of time due to a single qualifying reason. A reduced schedule leave is a leave schedule that reduces your usual number of working hours per workweek or hours per work day, and a continuous leave is taken in consecutive blocks of time.)
b) If Intermittent or reduced schedule leave, state the schedule you are requesting:

Section 6 - Authorization	
I do hereby certify that to the best of my knowledge the above information is true and correct. I understand that fraudulently requesting, obtaining and/ or misusing this leave will be cause for disciplinary action, up to and including dismissal from employment.	
Employee Signature	Date

Family and Medical Leave Act Request Form

HR-BEN-028

Section V – Agency Contact
This Medical Certification form must be sent to your specific Agency representative. Below is a list of all the Agency contacts. Please check the appropriate box next to your own Agency's contact.

Check the box for your agency.	Agency Name, Address, and Contact Information *Note: Bridges and Tunnels employees should contact their agency Human Resources Department*
☐	**MTA-HQ** Occupational Health Services 420 Lexington Avenue, Suite 2201 New York, NY 10170 Attn: Nurse Manager Email: FMLA@MTAHQ.ORG Fax: 212-878-0266
☐	**MTA-Bridges and Tunnels** Robert Moses Building Randall's Island New York, NY 10035-5199 Fax: 646-252-7911
☐	**MTA - Long Island Rail Road** Human Resources Department 93-02 Sutphin Boulevard Jamaica, NY 11435 Attention: FMLA Administrator Fax: 718-558-6824 Email: FMLA@LIRR.ORG
☐	**MTA – Metro-North Railroad** FMLA Administrator Human Resources Department 420 Lexington Avenue, 12th Floor New York, NY 10170 Attention: FMLA Administrator Phone: 212-340-2112 Fax: 212-340-2045 Email: MNRFMLA@MNR.ORG
☐	**MTA - NYCT / MaBSTOA/ SIRTOA/ MTABUS** Occupational Health Services 180 Livingston Street, Room 4023 Brooklyn, NY 11201 Attention: Office of the Medical Director

FMLA Certification of Health Care Provider Employee's Serious Health Condition

HR-BEN-069

Section 1 - Information and Instructions

The purpose of this form is to submit the required documentation for your FMLA request.

NOTE: You can request a leave of absence under the Family and Medical Leave Act ("FMLA") online at My MTA Portal, www.mymta.info. If you are unable to apply online, you must complete the HR-BEN-028 form 30 days prior to the start of your leave or as soon as possible. See the instructions at the top of the form for how to submit it to your agency.

Please complete Section 2 below before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave.

If this certification is requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Section 2 – Employee Information

Print Name	Last			First		M	Suffix	BSC ID:
Employer (check one)	☐ BSC	☐ B&T	☐ C&D	☐ HQ	☐ Police	☐ MaBSTOA	Department:	
	☐ SIR	☐ LIRR	☐ MNR	☐ MTA Bus	☐ NYCT		Job Title:	
Street Address							Regular Work Schedule	
City						State	Zip Code	
Phone (H)		Phone				Email		

Section 3 – Request for Leave

Leave Start Date	Leave End Date

Section 4 – Type of Leave Requested

a) State the type of leave you are requesting: ☐ Intermittent ☐ Reduced Schedule ☐ Continuous

(Intermittent Leave is separate blocks of time due to a single qualifying reason. Reduced Schedule is leave that reduces your usual number of working hours per work week or hours per work day, and a Continuous Leave is taken in consecutive blocks of time.)

b) If Intermittent or reduced schedule, state the anticipated frequency and duration:

Frequency: _____Times per ☐ Day ☐ Month ☐ Rolling Days ☐ Week ☐ Year

Duration _____Hours or _____Day(s) per episode

Employee Signature	Date

FMLA Certification of Health Care Provider
Employee's Serious Health Condition

HR-BEN-069

Section 5 – For Completion by HEALTH CARE PROVIDER		
The employee listed above has requested leave under the FMLA to care for your patient. Answer fully and completely all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Page 3 provides space for additional information, should you need it. **Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).** **Please be sure to sign the form on page 4.**		
Provider's Name	License Number	State
Type of Practice/ Medical Specialty		
Provider's Address		
City	State	Zip Code
Telephone	Fax	

PART A: MEDICAL FACTS

1. Approximate date condition commenced:

Probable duration of condition:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

☐ No ☐ Yes If yes, date of admission:

Date(s) you treated the patient for condition:

Will the patient need to have treatment visits at least twice per year due to the condition?

☐ No ☐ Yes

Was medication, other than over-the-counter medication, prescribed?

☐ No ☐ Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

☐ No ☐ Yes

If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy?

☐ No ☐ Yes If so, expected delivery date:

FMLA Certification of Health Care Provider
Employee's Serious Health Condition

HR-BEN-069

3. Use the information provided in Section 2 to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition:

   ☐ No ☐ Yes

   If so, identify the job functions the employee is unable to perform:

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period due to his/her medical condition, including any time for treatment and recovery?

   ☐ No ☐ Yes

   If so, estimate the beginning and ending dates for the period of incapacity:
   Begin date: End Date:

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition?

   ☐ No ☐ Yes

   If so, are the treatments or the reduced number of hours of work medically necessary?

   ☐ No ☐ Yes

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   Estimate the part-time or reduced work schedule the employee needs, if any:
   Hour(s) per day Days per week from through

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?

☐ No ☐ Yes

Is it medically necessary for the employee to be absent from work during the flare-ups?

☐ No ☐ Yes

If so, explain:

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency:	Times per	☐	week(s)	☐	month(s)
Duration:	Hours or		day(s) per episode		

ADDITIONAL INFORM ATION: IDENTIFY QUESTION NUMBER(S) RELATED TO YOUR ADDITIONAL ANSWER

Section 6 – Signature of Health Care Provider	
I do hereby certify that to the best of my knowledge the above information is true and correct.	
	Date

FMLA Certification of Health Care Provider
Employee's Serious Health Condition

HR-BEN-069

Section 7 – Agency Contact	
Check the box for your agency.	**Submit this form to your agency representative listed below.**
☐	**MTA HQ** Occupational Health Services 420 Lexington Avenue, Suite 2201 New York, NY 10170 Attn: Nurse Manager Email: FMLA@MTAHQ.ORG Fax: 212-878-0266
☐	**MTA Bridges and Tunnels** Robert Moses Building Randall's Island New York, NY 10035-5199 Fax: 646-252-7911
☐	**MTA Long Island Rail Road** Human Resources Department 93-02 Sutphin Boulevard Jamaica, NY 11435 Attention: FMLA Administrator Fax: 718-558-6824 Email: fmla@lirr.org
☐	**MTA Metro-North Railroad** FMLA Administrator Human Resources Department 420 Lexington Avenue, 12th Floor New York, NY 10170 Attention: FMLA Administrator Phone: 212-340-2112 Fax: 212-340-2045 Email: mnrfmla@mnr.org
☐	**MTA NYCT / MaBSTOA/ SIRTOA / MTABUS** Occupational Health Services 180 Livingston Street, Room 4023 Brooklyn, NY 11201 Attention: Office of the Medical Director

INFORMATION YOU NEED TO FILE A CLAIM

FORMS INCLUDED IN THIS DOCUMENT	ACCIDENT	DISABILITY	CRITICAL ILLNESS	CANCER	HEART OR STROKE	ICU / HOSPITAL INDEMNITY
Claimant's statement	●	●	●	●	●	●
HIPAA Authorization	●	●	●	●	●	●
Physician's Statement	●	●	●	●	●	●
Medical History Form		●		●		
Employer's Statement		●				
MATERIALS TO SUMBIT WITH YOUR CLAIM						
Itemized statements of medical charges	●			●	●	●
Police report (motor vehicle accidents)	●	●				
Discharge summary	●	●	●			
First report of injury		●				
Diagnostic report			●			
Pathology report			●	●		
Date of diagnosis			●			
Medicare, Medicaid, insurance statements				●	●	
Ambulance statement				●	●	●

WHAT HAPPENS AFTER YOU FILE A CLAIM?

Go to the next page and let's get started!

Transamerica Financial Life Insurance Company / Transamerica Life Insurance Company
Transamerica Claims PO Box 219 Cedar Rapids IA 52406-0219

TRANSAMERICA®

1 CLAIMANT'S STATEMENT

You must complete this Claimant's Statement for any claim you file. This information helps us determine how your policy/certificate covers your claim.

CLAIM TYPE

What is the policy/certificate you're filing this claim under? It can be more than one, so check all that apply:

☐ Accident ☐ Disability ☐ Critical Illness ☐ Cancer ☐ Heart/stroke ☐ Intensive Care / Hospital Indemnity

CONTACT INFORMATION

1. Primary insured's full name	2. Date of birth	3. Policy/certificate number	4. Social Security number

5a. Mailing address

5b. Street address

6. Phone number	7. Email address

8. Patient's full name	9. Date of birth	10. Relationship to insured

ABOUT YOUR INJURY OR ILLNESS

For questions 11-15, complete the information that applies to your situation. If you need more space for any question, you can use an additional sheet of paper and attach it to this form.

11. Nature of injury or illness

12. When did your symptoms first appear, or when did the accident occur? If this is related to an injury, explain fully how, when, and where accident occurred.

13. Date first treated or diagnosed	14. Were you hospital confined? Please include the hospital's name, address, and phone.
	☐ Yes: from_____ to _____ ☐ No

15. Do you have **Medicare?**
☐ Yes
☐ No

Do you have **Medicaid?**
☐ Yes
☐ No

Do you have other health insurance?
☐ Yes — Company name: _____
☐ No

1 CLAIMANT'S STATEMENT

INCOME SOURCES

Answer question 15 only if you're filing a disability claim. In that case, you also will need to have your employer complete the Employer's Statement, which is included with this document.

15. To the best of your knowledge, indicate if you have filed for, or are receiving income from, any of the following sources:

Salary continuance or sick leave ☐ Yes ☐ No If yes, how many hours since you last worked? _____

Extended illness benefit or time off ☐ Yes ☐ No If yes, how many hours since you last worked? _____

	APPLIED	RECEIVING	AMOUNT	FREQUENCY	DATES
Short-term disability	☐	☐	$_____	_____	_____ to _____
Worker's compensation	☐	☐	$_____	_____	_____ to _____
Social Security	☐	☐	$_____	_____	_____ to _____
Dependent Social Security	☐	☐	$_____	_____	_____ to _____
No Fault (income replacement)	☐	☐	$_____	_____	_____ to _____
Retirement / Pension	☐	☐	$_____	_____	_____ to _____
Permanent Total Disability	☐	☐	$_____	_____	_____ to _____
Other (identify below)	☐	☐	$_____	_____	_____ to _____

_____

Don't forget to sign and date this Claimant's Statement below: we can't evaluate your claim without your signature!

All the above answers and statements are true and complete and correctly recorded. I read and understand the appropriate Fraud Warning. I understand that the furnishings of forms by the company does not constitute an admission that there is any insurance coverage in force or payable.

For residents of 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. The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

_____ _____

Claimant's signature Date (MM/DD/YYYY)

_____

Printed name

2 HIPAA AUTHORIZATION

This authorization complies with the HIPAA Privacy Rule, and it's required for all claims. A copy of this authorization will be considered as valid as the original.

Note to claimant/personal representative: This authorization must be signed for us to receive medical records under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Although we may not need to obtain medical records to process your claim, we must obtain this form to avoid possible delays if medical information is needed.

I authorize all physicians, medical practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, long term care facilities (including assisted living facilities), home health care entities and other medical care institutions, medically related facilities, medical or hospital service and prepaid health plans, employers and group policy holders, contract holders and benefit plan administrators, state and federal governmental agencies (including law enforcement agencies), Social Security Administration, Internal Revenue Service and Veteran Administration facilities, coroners, medical examiners and any other person or entity that has any health information relating to the insured/patient named below (collectively, the "Providers") to disclose the **entire medical record** and any other protected health information concerning the insured/patient to the Transamerica Financial Life Insurance Company and/or Transamerica Life Insurance Company (the "Companies"), their affiliates and reinsurers, and any business associate, agent, employee, representative, investigator, benefit plan administrator, consumer reporting agency (including MIB, Inc. formerly known as the Medical Information Bureau) or independent claim administrator acting on behalf of any of the Companies (the "Permitted Recipients"). This authorization includes release of any oral, written, or electronic information, records, documents, or knowledge concerning any medical care, medical advice, diagnosis, treatment or supplies, including psychiatric or mental health records (excluding psychotherapy notes), prescription drug information, substance abuse records, medical records, medical notes, and medical recordings. This authorization also consents to disclosure of information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, AIDS and sexually transmitted diseases, to the extent permitted by state law.

By my signature below, I acknowledge that any agreements the insured/patient has made to restrict his or her protected health information do not apply to this authorization (e.g., they are temporarily revoked only as to this authorization) and I instruct the Providers to release and disclose the **entire medical record of the insured/patient and any other of their protected health information as noted above** without restriction.

The information disclosed is for the purpose of claims processing, including but not limited to evaluating contestability, eligibility determination, and/or benefit determinations by the Permitted Recipients.

This authorization shall remain in force for 24 months, or in the case of long-term care or disability claims for the duration of the claims under such policy, whichever is longer, following the date of my signature below. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Companies at Attention: Consumer Affairs Department, 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499. Alternatively, I may revoke this authorization by sending a written revocation directly to the Providers with a copy sent to the Companies. I understand that a revocation is not effective to the extent that any of the Providers has relied on this authorization or to the extent that the Companies have relied on a signed authorization or have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing

2 HIPAA AUTHORIZATION

privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the Companies will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and their own privacy policies. I understand that I have a right to receive the Notice of Health Information Privacy Practices and a copy of this signed authorization upon request.

I understand that Providers that are subject to the HIPAA Privacy Rule (not including the Companies) may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I do understand that if I refuse to sign this authorization to release the entire medical record of the insured/patient, the Companies may not be able to proceed with claims or eligibility processing or make any benefit payments. I acknowledge that (1) if I am signing on behalf of the insured/patient, I am legally permitted to do so as the personal representative of the insured/patient, and (2) I have received a copy of this authorization.

Don't forget to sign and date below: we can't evaluate your claim without this!

Name of insured/patient (please print)

Date of birth (MM/DD/YYYY)

Signature of insured/patient or their personal representative

Date signed (MM/DD/YYYY)

Description of personal representative's authority or Relationship to insured/patient

Policy or contract number

3 ATTENDING PHYSICIAN'S STATEMENT

This physician's statement is required for all claims. Give this page to your doctor to complete, then submit it together with the other parts of your claim.

1. Primary insured's full name	2. Policy or certificate number
3. Patient's full name	4. Patient's date of birth

5. For this patient, are you being paid by...

Medicare? ☐ Yes ☐ No

Medicaid? ☐ Yes ☐ No

Another insurance company? ☐ Yes — Company name: _____ ☐ No

6. Diagnosis (use ICD 10 Codes)	7. When did accident/symptoms first occur?	8. When did patient first consult you for this condition?

9. For pregnancy claims, give due date and delivery type.	10. For cancer claims: to your knowledge, has the patient ever had cancer prior to this diagnosis? ☐ No ☐ Yes (date) _____

11. List all dates of treatment (including surgical procedures, hospitalizations, ICU) and include the date charges of each treatment/procedure. Use current CPT codes.

12. Is the patient still under your care for this condition? If no, give name and address of new treating physician: ☐ Yes ☐ No	13. Did you advise the patient to cease work? ☐ Yes, from _____ to _____ ☐ No	14. Dates of total disability for this condition (from/to): 14b. Next treatment date:

15. If the patient was released to light duty due to this condition, give date range:	16. Was the patient unable to perform two or more activities of daily living due to this condition? If so, which ones? ☐ Yes ☐ No

CONTACT INFORMATION

Street address	City	State	ZIP

Phone number	Tax Identification Number	Degree

_____ _____

Physician's signature Date (MM/DD/YYYY)

_____

Printed name

EMPLOYER'S STATEMENT

You need to submit this page only if your claim is a **disability claim.** Give this page to your employer to complete, and then submit it together with the other parts of your claim.

1. Company Name			2. Phone number
3. Street address	4. City	5. State	6. ZIP
7. Full name of employee / insured person			8. Social Security number
9. Date this employee / insured person was last actively at work			
10. Employee / insured person's job title/major job duties (Attach a copy of job description)			
11a. Did disability occur on the job? ☐ Yes ☐ No	11b. Job classification ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very heavy		
12. If the employee were medically cleared to return to work with restrictions, or on light duty, can you accommodate? ☐ Yes ☐ No — If no, attach letter explaining why accommodation is not possible			
13. Date employee/insured person returned to work: __/____/____ ☐ Full time ☐ Part time ☐ Light duty	14. If "Part time" due to partial disability, provide earnings: $_____ from/to dates _____		
15. Employee/insured person's status of employment after first day absent: ☐ Active ☐ Leave of absence ☐ Laid off ☐ Retired ☐ Terminated ☐ Other: _____			
16. Employee/insured person's current status of employment: ☐ Active ☐ Leave of absence ☐ Laid off ☐ Retired ☐ Terminated Effective: _____			17. Annual salary
18. To the best of your knowledge, indicate if employee/insured person has filed for/is receiving income from any of these: Salary continuance/Sick leave ☐ Yes ☐ No If yes, indicate number of hours as of last date worked: _____ EIB or PTO ☐ Yes ☐ No If yes, indicate number of hours as of last date worked: _____ Worker's compensation ☐ Yes ☐ No If yes, indicate number of hours as of last date worked: _____			

The above statements are true and complete to the best of my knowledge and belief.

Signature of Employer's authorized representative

Date (MM/DD/YYYY)

Printed name

Title

Phone number

Transamerica Financial Life Insurance Company / Transamerica Life Insurance Company
Transamerica Claims PO Box 219 Cedar Rapids IA 52406-0219

TRANSAMERICA

MEDICAL HISTORY FORM

You need to submit a medical history form for any disability claim, and other policies may require it too — so if you're not sure if your claim requires it, go ahead and fill it out. Submit it together with the other parts of your claim.

INSURED PERSON'S DETAILS

Name of insured person	Social Security number

Policy/certificate number(s)

DETAILS ABOUT MEDICAL PROVIDERS

Please provide information about all the medical providers (including doctors and hospitals) the insured person consulted for treatment related to this claim. We'll then request information about their treatment of the insured to help us understand how the policy covers the claim. You can attach extra pages if you need more space.

Family physician name			Phone number	
Street address	**City**		**State**	**ZIP**
Reason for visit		**Dates consulted or year treated**		

OTHER PROVIDER — if applicable

Provider name			Phone number	
Street address	**City**		**State**	**ZIP**
Reason for visit		**Dates consulted or year treated**		

OTHER PROVIDER — if applicable

Provider name			Phone number	
Street address	**City**		**State**	**ZIP**
Reason for visit		**Dates consulted or year treated**		

MEDICAL HISTORY FORM

OTHER PROVIDER — if applicable

Provider name		Phone number	
Street address	City	State	ZIP
Reason for visit		Dates consulted or year treated	

DETAILS ABOUT MEDICATIONS

Please provide details about the medications the insured used for any treatment related to this claim (this information is usually on the prescription bottle or container). Attach extra pages if you need more space.

Medication name	Condition being treated	Prescribing physician name
Name and address of pharmacy		
Medication name	Condition being treated	Prescribing physician name
Name and address of pharmacy		
Medication name	Condition being treated	Prescribing physician name
Name and address of pharmacy		
Medication name	Condition being treated	Prescribing physician name
Name and address of pharmacy		

For residents of 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.

Claimant's signature

Date (MM/DD/YYYY)

Claimant's printed name

TRANSAMERICA®
Employee Benefits

Check company which issued policy:
☐ Transamerica Life Insurance Company
☐ Transamerica Premier Life Insurance Company

Request for Direct Deposi
Health Claims Payment

I (we) authorize the Company designated above to initiate direct deposit ☐	Start New DP ☐	Change Existing DP ☐	Stop Existing DP
Policy Owner Name (First, Last):		Policy Number:	
Bank Routing Number_____	Account No._____ ☐	Checking	Savings
Financial Institution's Name			
Signature _____			
Return Completed Form To: M3 Technology	Email Address: Service@m3tech.com		

I authorize Transamerica Life Insurance Company to initiate entries to credit your account for all future claim payments for this policy. This authorization will remain in effect until you submit a request to terminate the electronic payments. This authorization only applies to this policy. It does not apply to claim payments on a lif or any other policy. Claim Payments for other policies will remain unchanged. ACH payments do not apply to claims assigned to provider.

Please attach a Voided Check or a Verification Letter from your Bank

CLAIM FRAUD WARNINGS

Your state may require the following notice: 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.

Alabama. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska. A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

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.

Arkansas, District of Columbia, Louisiana, New Mexico, Rhode Island, Texas, 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 application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California. For your protection, California law requires the following to appear on this form. Any person who knowingly presents 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.

Colorado. It is unlawful to knowingly provide false, incomplete, or misleading facts or information to any 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 agents 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.

Delaware, Idaho, Indiana. 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.

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.

Kentucky, Pennsylvania. 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.

Maine, Tennessee, Virginia, 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.

Maryland. Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota. A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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 N. H. Rev. Stat. Ann. § 638:20.

New Jersey. Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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.

Ohio. Any person that knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

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.

MTA New York City Transit
Manhattan & Bronx Surface Transit Operating Authority

Application for Leave of Absence Due to Illness

TO BE PREPARED IN DUPLICATE

SIXTY PERCENT (60%) SUPPLEMENTARY PAY

Division _____ Department _____ Date _____ 20 ____

I, _____ Title _____ Pass No. _____

Rate _____ Pay Location _____ hereby apply for leave of absence from duty, with 60% pay, on account of illness or injury (from causes other than accident while on duty) in accordance with statement below:

Absent from _____ , 20____ , _____ A.M. P.M. to _____ , 20 ____ , _____ A.M. P.M. inclusive
If absence is due to a non-service accident, state where, when, and how accident occurred.

I was unable to work during said period because _____

Did accident occur while working for employer other than T.A.? _____

_____
(signature)

(This certification must be completely filled out by the attending physician before payment for sick leave at 60% pay will be passed upon.)

DOCTOR'S CERTIFICATION

Patient's Name _____ Age _____ Sex _____
first middle last

I hereby certify that the above named employee was treated by me on the dates and for the illness noted below:

1) Diagnosis _____

a. Patient's Symptoms _____

b. Objective Findings _____

2) Treatment: 1. _____
2. _____
3. _____

3) Dates of Treatment:

(A) Home _____

(B) Office _____

(C) Hospital _____

I further certify that this illness so incapacitated this employee that he was unable to perform his duties during the following period:

From _____ To _____

I make this certification knowing that the above mentioned employee will use it as the basis of an application for sick leave with 60% pay.

Date _____ Signature _____ M.D.

Address _____

Tel. No. _____

(OVER)

SHORT-TERM DISABILITY (STD) FORM
TWU L100 & ATU L726/L1056

HR-BEN-753

SECTION 1 – EMPLOYEE INFORMATION				
Print Name	Last First M.I. Suffix		BSC ID	Pass Number
Job Title	Department		Union	
Phone (H)	Phone (W)		Email	

Section 2– TO BE COMPLETED BY PENSION BENEFITS DESIGNATED OFFICIAL (OFFICE USE ONLY)		
☐ Approved ☐ Disapproved		
If disapproved: ☐ Untimely ☐ Incomplete ☐ Other (Explain)		
If approved, complete the following: MTA Consolidated Pensions has reviewed the attached Short-Term Disability (STD) form DB-450 or DB-300 if applicable for employees terminated within four weeks of employment, and the Divisional/Depot Pre-Application. The employee noted above may be eligible for STD benefits equivalent to 50% of average weekly wages (over the last eight weeks) up to a maximum of $170 per week, subject to New York State Disability law. The disability period covered by this authorization will not exceed a total of 26 weeks from the date of disability or 26 weeks in a 52-week period. This employee, if eligible, may be issued a STD check for the disability, subject to a seven-day waiting period (where applicable), for a continuous disability not before the following day and date_____.		
Print Name	Title	Pass No.
Signature	Date	

NYSIF
New York State Insurance Fund

NEW YORK STATE
NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

Please read instructions on page 2 carefully to avoid a delay in processing. You must answer all questions in Part A and questions 1 through 4 in Part B. Health care providers must complete Part B on page 2. Your employer should complete part C. However, do not delay submitting the form to NYSIF if you have difficulty getting part C completed.

PART A – CLAIMANT'S INFORMATION (Please Print or Type)

1. First Name:_____ MI:_____ Last Name:_____
2. Mailing Address:_____
   Number Street Apartment # City or Town State Zip Code
3. Daytime Phone #: _____ E-mail Address: _____
4. Social Security #: _____ 5. Date of Birth: _____ 6. Gender: ◯ Male ◯ Female ◯ Other
7. Describe your disability (if injury, also state how, when and where it occurred): _____
   _____
8. Date you became disabled: _____ Did you work on that day? ◯ Yes ◯ No
   Have you recovered from this disability? ◯ Yes ◯ No If Yes, date you were able to return to work: _____
   Have you since worked for wages or profit? ◯ Yes ◯ No If Yes, list dates: _____
9. Name of last employer prior to disability. If more than one employer in previous eight (8) weeks, name all employers. Average Weekly Wage is based on all wages earned in last eight (8) weeks worked.

LAST EMPLOYER PRIOR TO DISABILITY			PERIOD OF EMPLOYMENT		**Average Weekly Wage** (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
Firm or Trade Name	Address	Phone Number	First Day	Last Day Worked	
			Mo. Day Yr.	Mo. Day Yr.	
OTHER EMPLOYER during last eight (8) weeks			**PERIOD OF EMPLOYMENT**		**Average Weekly Wage** (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
Firm or Trade Name	Address	Phone Number	First Day	Last Day Worked	
			Mo. Day Yr.	Mo. Day Yr.	
			Mo. Day Yr.	Mo. Day Yr.	

10. My job is or was: _____ 11. Union Member: ◯ Yes ◯ No If Yes, _____
    Occupation Name of Union or Local Number
12. Were you claiming or receiving Unemployment prior to this disability? ..... ◯ Yes ◯ No
    If you did **not** claim or if you claimed but did not receive unemployment insurance benefits after LAST DAY WORKED, explain reasons fully: _____
    If you did receive unemployment benefits, provide all periods collected: _____
13. 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. Paid Family Leave ..... ◯ Yes ◯ No
       3. Unemployment Insurance Benefits ..... ◯ Yes ◯ No
       4. No-Fault motor vehicle accident ..... ◯ Yes ◯ No
          or personal injury involving a third party? ..... ◯ Yes ◯ No
       5. Long-term disability benefits under the Federal Social Security Act for *this* disability? ..... ◯ Yes ◯ No

IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 13, COMPLETE THE FOLLOWING:

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

14. In the 52 weeks before your disability began, have you received disability benefits for other periods of disability? ... ◯ Yes ◯ No
15. In the 52 weeks before your disability began, have you received Paid Family Leave? ..... ◯ Yes ◯ No
16. If you became disabled while employed or within four weeks of your last day worked, did your employer provide you with your rights under Disability Law within 5 days of your notice or request for disability forms? ..... ◯ Yes ◯ No

I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled. I have read the instructions on page 2 of this form and that the foregoing statements, including any accompanying statements are, to the best of my knowledge, true and complete.

_____ _____
Claimant's signature Date

An individual may sign on behalf of the claimant only if they are legally authorized to do so and the claimant is a minor, mentally incompetent or incapacitated. If signed by other than claimant, print info below, complete & submit Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records.

_____ _____ _____
On behalf of claimant Address Relationship to Claimant

PART B – HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type) NYSIF

THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY. THE ATTENDING HEALTH CARE PROVIDER SHALL COMPLETE AND RETURN TO THE CLAIMANT WITHIN SEVEN (7) DAYS OF RECEIPT OF THIS FORM. For item 7-d, you must give estimated date. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date in item 7-e. **INCOMPLETE ANSWERS MAY DELAY PAYMENT OF BENEFITS**.

1. First Name: _____ MI: ____ Last Name: _____
2. Gender: ◯ Male ◯ Female ◯ Other 3. Date of Birth: _____ 4. Phone #: _____
5. Diagnosis/Analysis: _____ Diagnosis Code: _____
   a. Claimant's symptoms: _____
   _____
   b. Objective findings: _____
   _____
6. Claimant hospitalized? ☐ Yes ☐ No From: _____ To: _____
7. Operation indicated? ☐ Yes ☐ No a. Type: _____ b. Date: _____

8. ENTER DATES FOR THE FOLLOWING	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 again be able to perform work (Even if considerable question exists, estimate date. Avoid the use of terms such as unknown or undetermined.)			
e. If pregnancy-related, please check box and enter the date ☐ estimated delivery date OR ☐ actual delivery date			

9. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease? ◯ Yes ◯ No If "Yes", has Form C-4 been filed with the Board? ☐ Yes ☐ No

I certify that I am a:

_____ _____ _____
(Physician, Chiropractor, Dentist, Podiatrist, Psychologist, Nurse-Midwife) Licensed or Certified in the State of License Number

_____ _____ _____
Health Care Provider's Printed Name Health Care Provider's Signature Date

_____ _____ _____
Health Care Provider's Address Phone Number Fax Number

IMPORTANT NOTICE TO CLAIMANT- READ THESE INSTRUCTIONS CAREFULLY

PLEASE NOTE: Do not date and file this form prior to your first date of disability. In order for your claim to be processed, Parts A and B must be completed.

1. If you are using this form because you became disabled while employed or you became disabled within four (4) weeks after termination of employment, your completed claim should be mailed within thirty (30) days to your employer or your last employer's insurance carrier. You may find your employer's disability insurance carrier on the Workers' Compensation Board's website, wcb.ny.gov, using Employer Coverage Search.
2. If you are using this form because you became disabled after having been unemployed for more than four (4) weeks, your completed claim must be mailed to: Workers' Compensation Board, Disability Benefits Bureau, PO Box 9029, Endicott, NY 13761-9029. If you answered "Yes" to question 13.B.1, please complete and attach Form DB-450.1.

If you do not receive a response within 45 days or if you have questions about your disability benefits claim, please call your employer's insurance carrier. For general information about disability benefits, please visit wcb.ny.gov or call the Board's Disability Benefits Bureau at (877) 632-4996.

Notification Pursuant to New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and Federal Privacy Act of 1974 (5 USC § 552a)
The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

HIPAA NOTICE - In order to adjudicate a workers' compensation claim or disability benefits claim, WCL 13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the insurance carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

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 must file with the Board an original signed Form OC-110A, "Claimant's Authorization to Disclose Workers' Compensation Records". This form is available on the WCB website (wcb.ny.gov) and can be accessed by clicking the "Forms" link. If you do not have access to the internet please call (877) 632-4996 or visit our nearest Customer Service Center to obtain a copy of the form. In lieu of Form OC-110A, you may also submit an original signed, notarized authorization letter.

An employer or insurer, or any employee, agent, or person acting on behalf of an employer or insurer, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

NEWBORN STIPEND

VOUCHER PROGRAM

ENROLL TODAY!

PROGRAM DETAILS:

-Having a newborn child up to a year old.

-Your leave time balances must be at zero consecutively. (AVA, Vacation, Sick and PLD)

-You must be out of work unpaid during requested stipend weeks.

-The benefit is $300 per week up to 4 weeks.

-You do not need to pass your one year probation to apply.

-Must be in good stand.

TWU LOCAL 100 - NYCTA CHILDCARE FUND

195 Montague Street 4th Floor, Brooklyn, NY 11201
Phone: 718.780.8700 - Fax: 718.222.1316
Email: Childcarefund@twulocal100ccf.org