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

1. Complete Section 1 of the Claim Form.

   Be sure to complete all requested information and sign and date the form where indicated. Incomplete forms will be returned to you and will delay payment of your claim. Please double-check that all information is provided and that you wrote your information clearly.

2. Have your Local Chairman (or other local officer) complete Section 2 of the Claim Form.

   Once you have completed step 1 above, forward your claim form to your Local Chairman or another designated local officer. Your Local Officer will complete Section 2. Be sure your Local Officer completes all the information requested in Section 2, prints his name and title and signs the form before you move on to the next step. Incomplete information will delay payment of your claim.

3. Have your physician complete Section 3 of the Claim Form.

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

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

SMART Voluntary Short Term Disability Plan
BUS Member Claim Form

Instructions: You must complete Section 1 of this form. Have your Local Officer complete Section 2 and your physician complete Section 3. Once all three sections are fully completed, you should mail, fax or email the form to:

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

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

SECTION 1: TO BE COMPLETED BY MEMBER

1. Member name (last, first, M.I.)	2. Social Security No.	3. Birth Date	4. Gender
		/ /	[ ] M [ ] F

5. Member Street Address	5.a. City	5.b. State	5.c. Zip Code

6. Phone Number	7. Cell Phone Number	8. Email Address

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

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

14. If disability is due to an illness that was caused by, or aggravated by, any employment that you have engaged in, provide complete details (attach a separate sheet if necessary).

15. If you are currently engaged in **any** employment for wage or profit, provide complete details, including date(s) of employment and weekly earnings.

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

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

Member Signature

X_____

Date

_____

(OVER)

SMART Voluntary Short Term Disability Plan
BUS Member Claim Form

SECTION 2 – TO BE COMPLETED BY A LOCAL OFFICER				
16. Member Name				
17. Effective Date of insurance	18. Occupation/job title			
19. Date Member last worked	20. Date Member scheduled to return to work			
21. Date Member returned to work	22. Member's wage $_____ per [ ]hour [ ] week [ ] year [ ] Hourly [ ] Salaried			
23. Member status on the last day worked	24. Current Member status			
25. Did injury or illness arise out of, or in course of, employment for wages or profit? [ ] Yes [ ] No				
26. Branch or division address		27. Phone Number		
28. Local officer phone number	29. Local Union Number	30. City	31. State	32. Zip
33. Printed name of local officer		34. Title		
Local officer signature X_____		Date _____		

LOCAL OFFICER INSTRUCTIONS

1. You will need to complete Section 2 above of this form for your member when they file a claim. Most of the fields are self-explanatory. This document points out a few items of importance.
   An incomplete Claim Form will delay the processing of your member's claim. Please be sure you have answered all questions completely and write legibly.

2. Item 16 Effective Date of Insurance: This information can be found in TD Connect by doing a Local Members search and clicking on the Dues tab. Under the section Voluntary Deductions, details on the members VSTD effective date will be displayed. If you have any difficulty locating this information, please contact the SMART Transportation Division (216-228-9400) for assistance.

3. Item 21 Member's Wage: This is the member's wage rate as of the date of disability.

4. Item 27 Local Officer Phone Number: Provide your phone number so that a claims adjuster may contact you if they have any questions to your responses above.

5. **IMPORTANT! Be sure to print your name and title (items 32 and 33) and sign your name and date the form where indicated.**

6. Return the Claim Form to your member.

Contact the SMART Transportation Division at (216) 228-9400, if you have any questions regarding the information being requested on the claim form.

SMART Voluntary Short Term Disability Plan
BUS Member Claim Form

SECTION 3: TO BE COMPLETED BY PHYSICIAN

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

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

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

SMART VOLUNTARY SHORT TERM DISABILITY PLAN

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

AUTHORIZATION FOR AUTOMATIC TRANSFERS

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

BANK NAME:_____ **BRANCH:**_____

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

CHECKING_____ **SAVINGS**_____

NAME ON ACCOUNT: _____
(Please Print)

ACCOUNT NUMBER: _____

ROUTING/ABA NO. _____

SIGNATURE: _____

DATE: _____

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

ATTACH A VOIDED CHECK HERE.