KEYS

TO PREGNANCY

ON THE JOB

Transit Employee Rights and Necessary Forms

TRANSPORT WORKERS UNION OF LOCAL 100
AFL CIO

Good Day

Here are some information that complied for anyone who is expecting the birth of a newborn and or going through the adoption process. I also took the liberty of attaching some paperwork (Pregnancy Packet/ What To Expect Packet) of things that may help out as well.

Did your Obstetrician-Gynecologist (OB-GYN) state that you have limitations with your pregnancy? Are you having complications during your pregnancy?

If you answered yes to any of these questions, your doctor should complete the paperwork for a Reasonable Accommodation. When one submits the paperwork they should ensure that they have a copy for their own records and the paperwork should be submitted to their immediate Supervisor. The paperwork can be submitted via email to keep a paper trail of all the parties involved. Also take the time to read the paperwork for a Reasonable Accommodation, to ensure you are fully abreast of what you are entitled to as a New York City Transit Employee.

Do you have Family Medical Leave Act (F.M.L.A.) Paperwork?

If you do have the paperwork, you should have your Obstetrician-Gynecologist (OB-GYN) complete the forms. The Family Medical Leave Act (F.M.L.A.) paperwork comes with instructions on what one should do once the paperwork is completed.

Do you have the paperwork for the Maternity/ Paternity Leave?

Here is how the Maternity/Paternity Leave works...According to the Memorandum Of Understanding, Employees are now paid two (2) weeks for the Maternity/ Paternity Leave. The two (2) weeks start upon the birth of a child, not the day of the discharge. The initial documentation should be submitted within three (3) days of the initial absence. One can either email or fax the documentation and this will suffice. One should be sure to keep confirmation of the slip if the paperwork is faxed.

Do you have Disability Insurance?

If you answered yes, the paperwork is attached as well for one to complete. You are entitled to receive payments after a fourteen (14) day waiting period for Transamerica.

Do I qualify for Short Term Disability?

If your time is exhausted you may be entitled to Short Term Disability. Please refer to the attached for more information.

Exhausted Your Sick Time?

If you exhausted your Sick Time you might be eligible for 60%. Depending on the amount of time you have accrued while working as a New York City Transit Authority you may be eligible for this as well. Here is the breakdown.

Employees with less than 4 years of service at the beginning of the sick leave year.....0 days

Employees with service from 4 years up to but not including 8 years at the beginning of the sick leave year:.....
15 days

Employees with service from 8 years up to but not including 14 years at the beginning of the sick leave year:.....
30 days

Employees with service from 14 years up to but not including 20 years at the beginning of the sick leave year:.....
60 days

Employees with 20 years or more of service at the beginning of the sick leave year .....90 days

*Unless otherwise indicated, a "year" is defined as the period between May 1 and April 30.

to apply for the 60% you must complete the proper paperwork (the yellow application form)

The Union also has a Newborn Stipend Fund and here is how it works.

Once you are put on your leave and you have exhausted all of your balances you are entitled to this payment. This included but is not limited too Sick Leave Balance, AVA, Vacation, and a PLD balances. A Member would pick a time period which equals a month where they did not have any of this time. The Union will contact timekeeping to verify that all of the time was exhausted. This program is not gender biased as long as the Member was out and exhausted all of their balances. If you had or have a baby under twelve (12) months you are entitled as well. The maximum you can receive is $800.00.

To receive the application feel free to call the Training and Upgrading Fund (718) 780-8700.

Expression Of Milk…..

If you are returning to work and you have to Express Milk, under the New York State Law you have thew right to Express Milk in the Work Place free from harassment and or discrimination. To find out the designated location in your department for you to Express Milk reach out to the following individual.
Miss. Dawn Rose
Phone: 718-694-3085
Email: dawn.rose@nyct.com

Want to request more bonding time to be with your newborn if the Family Medical Leave Act (F.M.L.A.) request was denied?

One should request a Leave Of Absence with their respective department heads. The Leave Of Absence must be submitted on the correct "Leave Of Absence" Form.

KEEP COPIES OF EVERYTHING FOR YOUR PERSONAL FILES.
ALSO KEEP RECORD OF ANYONE YOU SPEAK TO DURING YOUR LEAVE.
LASTLY…..*Congratulations*

Crystal A. Young
TWU Shop Steward
347-420-3246
crystaltwushopsteward@gmail.com

REASONABLE ACCOMMODATIONS FOR JOB APPLICANTS AND EMPLOYEES WITH A DISABILITY, OR A PREGNANCY-RELATED CONDITION

Policy Number	Responsible Department	Effective Date	Page
11-066	Human Resources	March 27, 2019	Page 1 of 10

I. PURPOSE

The Metropolitan Transportation Authority ("MTA"), and its current and future subsidiary and affiliate entities, are committed to providing Reasonable Accommodations to employees and applicants for employment with known Disabilities and Pregnancy-Related Conditions, as required by applicable law. This Policy Directive sets forth the procedure for processing Reasonable Accommodation requests from employees and applicants for employment.

II. SCOPE

This Policy Directive applies to the MTA and its current and future subsidiary and affiliated entities, including: MTA Headquarters; MTA New York City Transit, including the Manhattan and Bronx Surface Transportation Operating Authority and the Staten Island Rapid Transit Operating Authority; MTA Metro-North Railroad; MTA Long Island Rail Road; MTA Bridges and Tunnels; MTA Capital Construction Company; and MTA Bus Company (each an "Agency", and collectively "MTA").

III. DEFINITIONS

A. Designee for Reasonable Accommodation ("DRA") and Designee(s): The individual at each Agency designated by the Agency's Head of Human Resources to oversee the Reasonable Accommodation request process set forth in this Policy Directive at that Agency. The DRA and/or the department may designate individuals to handle and process Reasonable Accommodation requests for certain units, divisions, sub-divisions or departments of an Agency.

B. Disability: Any physical, mental or medical impairment resulting from anatomical, physiological, genetic or neurological conditions that prevents the exercise of a normal bodily function or is demonstrable by medically accepted clinical or laboratory diagnostic techniques, or a record or history of such an impairment, or a condition regarded by others as such an impairment. Disability also includes such physical, mental or medical impairment that significantly limits or restricts a major life activity such as hearing, seeking, speaking, breathing, performing manual tasks, walking, caring for oneself, learning or working.

C. **Essential Job Functions:** The primary job duties and activities that an employee must reasonably be able to perform, with or without a Reasonable Accommodation. These are functions that are fundamental to the position; a function is essential if not performing that function would fundamentally change the job or occupation for which the position exists.

D. **Pregnancy-Related Condition:** A medical condition related to pregnancy or childbirth that inhibits a normal bodily function or is demonstrable by medically accepted clinical or laboratory diagnostic techniques. The term is limited to conditions which, upon the provision of a Reasonable Accommodation, do not prevent the person from performing in a reasonable manner the activities involved in the job or occupation sought or held.

E. **Qualified Person with a Disability or a Pregnancy-Related Condition ("Qualified Person"):** A person with a Disability or Pregnancy-Related Condition who can reasonably perform the essential functions of the job or occupation sought or held, with or without a Reasonable Accommodation, and who satisfies the requisite skill, experience, education and other job-related requirements of the position that the individual holds or desires.

F. **Reasonable Accommodation:** The modifications or adjustments to a job application process that enables a Qualified Person to be considered for the position sought. This term also means modifications or adjustments to the work environment or the manner or circumstances under which a job is performed that permit a Qualified Person to reasonably perform the Essential Functions of their job.

G. **Reasonable Performance:** The ability to reasonably perform the activities involved in the job or occupation means the ability, with or without a Reasonable Accommodation, to satisfactorily perform the Essential Functions of the job as established by the Agency. Reasonable Performance is not perfect performance or performance unaffected by the Disability or Pregnancy-Related Condition, but reasonable job performance meeting the employer's needs to achieve its business goals.

H. **Undue Hardship:** Undue Hardship means significant difficulty or expense to the Agency.

IV. POLICY

It is the policy of the MTA to provide Reasonable Accommodations to Qualified Persons with Disabilities or Pregnancy-Related Conditions who are employees or applicants for employment, and who request such accommodations or whose need for such accommodations is obvious or known to the MTA, unless to do so would result in an Undue Hardship to the MTA. All MTA employees must cooperate with requests for information and assistance in addressing Reasonable Accommodation requests.

V. PROCEDURES

A. Designation of DRA/Designee(s):

a. Each Agency shall designate a DRA to oversee the Reasonable Accommodation process Agency-wide, as set forth in this Policy Directive. To the extent deemed necessary by the Agency, the Agency may designate an individual or individuals to handle and process Reasonable Accommodation requests for a particular area, unit or department, at the direction of the DRA.

B. Submitting a Reasonable Accommodation Request:

a. **Job Applicants**: A job applicant may request a Reasonable Accommodation at any time, orally or in writing, from the Human Resources Department or hiring manager, who must communicate the request to the DRA or their designee(s). An applicant must fill out the **Application to Request Reasonable Accommodation of Disability (Exhibit A hereto).** The Agency may ask the applicant to provide supporting medical documentation of the Disability or Pregnancy-Related Condition. Where applicable, the Agency should work with the Department of Citywide Administrative Services and/or exam providers in processing Reasonable Accommodations for applicants.

b. **Requests from current employees:** Current employees may request a Reasonable Accommodation at any time, orally or in writing, from their supervisor or manager, Human Resources, or the Agency DRA or their designee(s).

Human Resources, supervisors and managers who receive a request for accommodation must let the DRA know of the request and the employee must fill out the **Application to Request Reasonable Accommodation of Disability (Exhibit A hereto).** The Agency may ask the employee to provide supporting medical documentation of the Disability or Pregnancy-Related Condition.

An employee requesting a Reasonable Accommodation on a recurring basis, such as the assistance of a reader or sign language interpreter, must submit the Application form only for the first request. However, the employee requesting a Reasonable Accommodation must give notice, where practicable, of the need for assistance each subsequent time the Reasonable Accommodation is needed.

C. **Requests That Can be Resolved Based on Initial Information/Obvious Disabilities**: Some requests for Reasonable Accommodation can be approved at the initial stages of the process because the Disability or Pregnancy-Related Condition and need for a Reasonable Accommodation is obvious or easy to resolve, and/or because sufficient information has been provided by the requestor in the Application. In such case, the DRA or their designee(s) may, in consultation with the department or others as necessary, approve the request in writing by sending the requestor the **Initial Response to Request for Accommodation (Exhibit B)** with the box checked that the request has been approved.

If a manager or supervisor believes that an employee may need a Reasonable Accommodation for a Disability or Pregnancy-Related Condition, but that employee has not requested a Reasonable Accommodation, the manager should contact the DRA or their designee(s) for guidance.

D. **Requesting Additional Information**: If the Disability or Pregnancy-Related Condition and the need for a Reasonable Accommodation are not obvious or already known, or if additional information is necessary for evaluation of the request, the Agency may ask the requestor for such additional information, including medical documentation evidencing that the requestor has a Disability or Pregnancy-Related Condition and the need for a Reasonable Accommodation.

The DRA or their designee(s) may use the **Notification of Need for Additional Information (Exhibit C)** form to request this information, along with providing the requestor with additional information to take to their medical provider if appropriate. Employees or their physicians must send medical information in response to Agency requests directly to the Agency's occupational health services.

E. **Medical Examination/Communication with Employee's Physician:** The Agency may ask the requestor to sign the appropriate authorization giving the Agency's occupational health services personnel the ability to communicate directly with the requestor's physician, if the information provided by the requestor is not adequate to resolve the request. The Agency may also require the requestor to provide additional information if the initial information is not sufficient, or to submit to a medical examination by a professional of the Agency's choosing where appropriate. The Agency must pay any costs associated with the examination, unless otherwise specified by an applicable collective bargaining agreement.

F. **Failure to Cooperate:** If the requestor fails to cooperate in the interactive process, such as by refusing to submit documentation, failing to allow occupational health services to speak with the requestor's physician, or refusing to submit to a medical examination, and such information or documentation is necessary to complete the Reasonable Accommodation process, then the DRA may deny the request.

G. **Confidentiality Requirements**: Medical information obtained relating to the Reasonable Accommodation process must be kept confidential. This means that all medical information that the Agency obtains in connection with a request for Reasonable Accommodation must be kept in files separate from the individual's personnel file. This includes the fact that a Reasonable Accommodation has been requested or approved and information about the person's limitations. It also means that any Agency employee who obtains or receives such information is strictly bound by these confidentiality requirements.

The DRA or their designee(s) may share certain information with an employee's supervisor or other Agency official(s) as necessary to make appropriate determinations on a Reasonable Accommodation request. Under these circumstances, the DRA or their designee(s) will inform the recipients about these confidentiality requirements.

The information disclosed will be no more than is necessary to process the request. Managers and/or supervisors are not entitled to see or obtain copies of medical records. The Agency may also share information concerning the Disability or Pregnancy-Related Condition as necessary to first aid and safety personnel, for example, in evacuations or emergency situations.

H. **Determination of Request for Reasonable Accommodation**: The final review process takes place once the DRA or designee(s) have received adequate information and documentation.

During the final review, the Agency's DRA or their designee(s) must determine (i) whether the requestor is a Qualified Person with a Disability or Pregnancy-Related Condition; and if so, (ii) whether there is a Reasonable Accommodation that would allow the requestor to reasonably perform the essential functions of the position without creating an Undue Hardship to the Agency.

a. During this process, the DRA or their designee(s) must engage in the following communications and interactive process:

i. The individual requesting the Reasonable Accommodation, and the DRA or their designee(s), should communicate with each other about the request, the nature of the issue that is generating the request, how the Disability or Pregnancy-Related Condition is prompting a need for a Reasonable Accommodation, and alternative Reasonable Accommodations that may meet an individual's needs. The DRA or their designee(s) shall keep the requestor updated throughout the process.

ii. The DRA or their designee(s) will work with the Agency's occupational health services where appropriate, who will review all medical information and determine whether a Disability or Pregnancy-Related Condition exists and whether the requested accommodation (or other accommodations) are medically appropriate.

iii. In determining whether or not an accommodation is reasonable, the Agency will consider the nature of the job duties and essential functions of the job, as well as the individual's Disability or Pregnancy-Related Condition. By way of example only, some common types of Reasonable Accommodations may include, but are not limited to: making facilities more readily accessible to individuals with Disabilities; acquisition or modification of equipment; modified work schedules, adjustments to work schedules for treatment or recovery; reassignment to an available, budgeted position for which the employee is qualified, if feasible under any applicable collective bargaining agreements; adjustment of examinations; providing interpreters or providing high or low assistive technology, such as voice recognition software; and, in certain functions, accommodations relating to firearms privileges and accommodations relating to uniforms (including belts and other accessories).

iv. The DRA or their designee(s) should also communicate with the employee's supervisor or manager and/or department to determine if the requested accommodation is operationally feasible or if it constitutes an Undue Hardship. If the accommodation proposed may have a direct impact on the terms of a collective bargaining agreement, the DRA or their designee(s) must confer with the Agency's labor relations department to resolve any conflict with the collectively bargained rights of other employees.

v. In determining whether an Undue Hardship exists, the following factors, among others, may be relevant, depending on the circumstance: the size of the operations, project, or department, number of employees, number and type of facilities, and size of budget; the type of operation, including the composition and structure of the work force; the impact of the requested accommodation on other employees within the unit; the nature and cost of the requested accommodation; and the impact on any applicable collective bargaining agreement.

vi. The Agency may, at its discretion, convene a Reasonable Accommodations Committee (which may include representatives from the employee's department, Human Resources, Labor Relations, Legal, occupational health services, and ADA Compliance) to discuss the requested accommodation and its impact on the Agency's overall operations. All of these discussions shall be subject to the Confidentiality Requirements contained in paragraph "G" above.

vii. The DRA or their designee(s) should seek the advice of the Agency's Legal Department, where appropriate, to resolve any questions.

b. If more than one alternative is identified as a Reasonable Accommodation, the Agency may choose the accommodation that best meets its needs. However, the Agency should take into consideration the requestor's preferences whenever possible.

c. A Reasonable Accommodation is not required to be provided for behaviors that do not meet workplace behavior standards that are consistently applied to all similarly-situated employees, even if these behaviors are caused by a Disability or Pregnancy-Related Condition. A Reasonable Accommodation is also not required to be provided where the Disability, Pregnancy-Related Condition, or the proposed accommodation itself, poses a direct threat, or a significant risk of substantial harm to the health or safety of the employee or others that cannot be eliminated or reduced by an alternative or additional Reasonable Accommodation.

d. During the pendency of a request for Reasonable Accommodation, the Agency may, without prejudice to its final determination, implement interim steps or temporary accommodations to assist the requestor.

I. **Notification after Review Process**: After the employee or applicant provides the DRA or their designee(s) with the information necessary to properly review and assess the request for accommodation, the DRA will make all reasonable efforts to provide the individual with the **Notice of Agency Determination (Exhibit D**) within 30 calendar days from receipt of the information necessary for its decision.

In this form, the DRA should check the applicable box for (i) granting the accommodation requested; (ii) granting a different accommodation or (iii) denying the accommodation. Before denying a request for Reasonable Accommodation, the DRA or their designee(s) must engage in the interactive process and communications in Section V.H.a. above, to explore all options for a Reasonable Accommodation.

J. **Employee's/Applicant's Rights Concerning Agency Determination**: If the requestor is dissatisfied with the Agency's determination, they may (i) pursue an internal discrimination complaint with the Agency's Diversity/EEO Office if they believe that discrimination or retaliation in violation of Agency policies has occurred; and/or (ii) pursue all other available rights including but not limited to filing a complaint with administrative agencies such as the Equal Employment Opportunity Commission, New York State Division of Human Rights, or any other available forum.

K. **Retaliation**: Retaliation or harassment against an applicant or employee who has complained of Disability or pregnancy discrimination, or who has sought or been granted a Reasonable Accommodation for a Disability or Pregnancy-Related Condition, or who has participated in any related investigation, is prohibited. Violation of this prohibition will result in disciplinary action, up to and including termination.

L. **Record-Keeping:** The DRA shall maintain records of all requests for Reasonable Accommodation including completed versions of all forms. Records shall be kept in accordance with Agency record-keeping policies, but in no event less than two (2) years from the date the Notice of Agency Determination was sent to the requestor.

M. **No Creation of Rights**: This Policy Directive does not create any legal rights, contractual or otherwise, for any employee or job applicant, nor is it intended to bind the MTA in any way not otherwise contained in applicable law. The MTA reserves the right to revise, add to, or delete any portion of this Policy Directive at any time, in its sole discretion, without prior notice to job applicants or employees.

VI. EXHIBITS

A. Application to Request Reasonable Accommodation for a Disability or Pregnancy-Related Condition

B. Initial Response to Request for Accommodation

C. Notification of Need for Additional Information

D. Notification of Agency Determination

Application to Request
Reasonable Accommodation of a Disability

Application for reasonable accommodation must be made to the Departmental Human Resources Representative. All information is confidential, and personnel should handle each request as such. Also, all medical information is confidential and maintained separately from personnel records.

Employee Form

Name _____

Pass Number _____

Civil Service Title _____

Job Title Sought/Held (if different) _____

Home Address _____

Dept. /Division _____ Work Location _____

Telephone Number _____ Cell Number _____

Email address: _____ How can we contact you? _____

Check one:

☐ Employee seeking new position ☐ Employee seeking accommodation in current title

☐ Applicant for new hire from certified list ☐ Applicant for new hire/non-list

1. What is your disability or medical condition?

2. Does this impairment substantially limit one or more of your major life activities? If so, what major life activity is limited and how?

3. Does this impairment impede a bodily function? Or is this impairment demonstrable by a medically accepted diagnostic technique?

4. What are your essential job functions, if known?

5. What is the requested reasonable accommodation?

6. Will the requested accommodation allow/permit you to perform the essential functions of your job? If so, how?

7. Are there any job functions that you will not be able to perform even with the requested accommodation? If so, please list the functions that the employee will not be able to perform.

The review process of your request may include:

1. An interview with you.
2. An evaluation by Occupational Health Services (OHS)
3. Recertification may be required periodically.

Submitted by:

Employee Print Name	Employee Signature
Date	

Received by:

Employee's Supervisor/Manager	Date
Labor Relations (Attorney) [if applicable]	Date
Department of Human Resources	Date
ADA Compliance Officer	Date

☐ Concur ☐ Do not concur ☐ Alternative Accommodation

Medical Form

(To be completed by your medical doctor)

_____ _____

Name of Employee Pass Number

_____

Home Address

I certify that I have examined the patient on _____.
[date]

This patient has/is being treated by me since _____.
[date]

This person has the following disability/diagnosis_____

_____

_____

Date of onset_____

Expected duration of disability_____

This impairment has been diagnosed using the following medically accepted diagnostic technique(s)_____

_____

_____

This impairment (Please check all that apply)

☐ Substantially limits one or more of the patient's major life activities.

☐ Impedes the patient's normal bodily functions.

I have reviewed a copy of the employee's essential job functions.

☐ Yes ☐ No

I am recommending the following reasonable accommodation be provided to this employee:

Will the requested accommodation allow the employee to perform the essential functions of his/her job? If so, how?

Signature of doctor (MD or DO)

Date

Physician's Stamp

Physician's Signature/Tax ID No.

Memorandum

New York City Transit

Date April 6, 2009

To All Employees

From Valerie Bynoe-Kasden, Vice President, Human Resources

Re **NYS Labor Law 206-c: Nursing Mothers and the Expression of Milk in the Workplace**

In accordance with Section 206-c of New York State Labor Law, MTA New York City Transit Authority, including the Manhattan and Bronx Surface Transit Operating Authority (MaBSTOA) and the Staten Island Rapid Transit Operating Authority (SIRTOA) (hereinafter collectively referred to as MTA NYC Transit) will provide certain assistance in the workplace for employees who are nursing mothers. The following are the benefits afforded to those employees who wish to continue the expression of breast milk upon return to work following the birth of a child:

- For up to three years following the birth of a child, employees who are nursing are permitted to use up to thirty minutes during any regularly scheduled meal or break period for the purpose of expressing breast milk. In the alternative, an employee may also take unpaid break time of up to 30 minutes for this purpose.

- MTA NYC Transit will make reasonable efforts to provide a private room or other location for the purpose of expression of breast milk. If unable to provide a private room, a location will be designated by MTA NYC Transit which will not be open to others when an employee is expressing breast milk. This room will be in close proximity to the employee's work area.

- MTA NYC Transit will not discriminate in any way against an employee who chooses to express breast milk in the workplace. Any MTA NYC Transit employee who violates this policy will be subject to disciplinary action, up to and including dismissal.

In order to be eligible for these benefits, the employee must provide advance notice to the designee from her department (see attached list of designees) of the need for the break time and location for expression of breast milk, preferably prior to returning to work after the birth of the child, but in any event, at least

seven working days prior to the date the employee will need such break time and location. Such request should indicate the number of breaks needed for this purpose. It should be noted that MTA NYC Transit may postpone scheduled unpaid break time for up to 30 minutes if the employee cannot be spared from her duties until appropriate coverage is arranged.

The employee is required to store all expressed milk in closed containers and must bring such milk home at the end of her tour of duty. MTA NYC Transit is not responsible for securing refrigeration for purposes of storage.

Any employee utilizing this benefit must cooperate with all MTA NYC Transit efforts to establish a suitable location and reasonable break time for the purpose of the expression of breast milk in the workplace.

A list of departmental designees is attached.

Departmental Designees: Re Compliance with Legislation for Nursing Mothers and Expression of Breast Milk

Department	Contact	Title	Phone
Office of the President	Priscilla Sullivan	Admin Manager	646-252-5800
Office of the E.V.P	Priscilla Sullivan	Admin Manager	646-252-5800
Dept of Security	Jenny Centeno	SA 1	718-694-1813
Corporate Communications			
Marketing & Service Info	Darlene Pantophlet	Conf. Secty 11	646-252-6801
	Sonia Jhagroo	ATC SS 11	**6**46-252-6802
Customer Service	Christine Somerville		
Divisions			
AFC Program Mgmt.	Michael Wedeck	Asst. Budget Chief	718-694-5001
Office of the Controller	Laura Larsen	Manager	646-252-6615
Capital Planning/Budget	Ben Schmutter	Director, Budget Control	646-252-4632
Government Relations	Caroline Jackson Colley	Asst. Director	646-252-2651
Office of EEO	Paula White	Conf. Secty	718-694-1919
Materiel	Joan Ashe	Manager	646-252-6130
OMB	Claire Janey	Conf. Secty	646-252-2362
Operations Planning	Renata Zidrashko	ASA	646-252-5512
Revenue Control	Peggy Bostic	Manager	347-643-8744
Supply Logistics			
C/Warehousing Ops	James Manning	Chief Officer	347-643-7480
Northern Field Ops	Kenneth Acevedo	Superintendent	212-544-3278/3277
Ops Plng & Analysis	James Summers	Director	347-643-7577
Southern Field Ops	John Milley	Chief Officer	718-927-8700
TIS	Fione Robe	Conf. Secty	646-252-5435
CPM	Joe Gorman	Director	646-252-3746
	Lauren Billings	CMP SP 2	646-252-4642

Departmental Designees: Re Compliance with Legislation for Nursing Mothers and Expression of Breast Milk

Office of System Safety	James Bromfield	Director, SARD	646-252-5778
Dept of Law	Shari Saunders	Director	718-694-3846
Dept of Administration	OHS-Wendy Malliet	Senior Director	347-643-8160
HR-Cheryl McCall	Senior Director	Senior Director	347-643-8444
Research& Tr-LR	Hettie Pope	Senior Director	646-252-2738
Labor Relations	Rhonda Hogan-Brock	Chief of Staff	646-252-2872
Investigations	Linda Wilson	Asst. Chief Officer	718-694-4637
Engineering, Subways	Anthony Febrizio	ACO	646-252-2600
Dept of Buses	AGMs	AGM of Bus Depot	718-927-7621
Paratransit	Maritza Trancoso	Fin/Admin Services Officer	718-393-4004
Dept of Subways			
IRT East	David Knights	Group GM	718-694-4943
IRT West	Lou Brusati	Group GM	718-694-4943
BMT/IND Group	Greg Lombardi	Group GM	718-566-3710
Districts 3	John Johnson	CTO	212-712-4100
District 5	Brenda Sidberry	CSO	646-252-5130
Workforce Development	Bonnie Lee	Director	646 252 5205

DIVISION CONTACTS

Location	Title	Name	Office	Nextel
BRONX DEPOTS				
Gun Hill	AGM-Depot Operations	Jack Montello	(718) 430-4810	588
Kingsbridge	AGM-Depot Operations	Derrick Lawson	(212) 544-3456	816
West Farms	AGM-Depot Operations	Joseph King	(718) 319-7582	6175
STATEN ISLAND DEPOTS				
Castleton	AGM-Depot Operations	Louis Battaglia	(718) 981-8725	724
Yukon	AGM-Depot Operations	Harry Caddell	(718) 494-5634	722
BROOKLYN DEPOTS				
Grand Avenue	AGM-Depot Operations	James Courtney	(347) 694-1610	278
Flatbush	AGM-Depot Operations	John Carroll	(347) 643-5710	5117
Jackie Gleason	AGM-Depot Operations	John Maestri	(347) 643-5265	5067
Ulmer Park	AGM-Depot Operations	Louis Derrico	(718) 996-7980	1938
MANHATTAN DEPOTS				
100th Street	AGM-Depot Operations	Stephanie Bogerd	(212) 712-4649	567
126th Street	AGM-Depot Operations	Michael Broe	(212) 712-5600	5109
Amsterdam	AGM-Depot Operations	Gerald Moen	(347) 672-7459	4272
Manhattanville	AGM-Depot Operations	Devon Rogers	(212) 712-4351	3576
Michael J. Quill	AGM-Depot Operations	Michael Ribosh	(212) 712-5020	718
QUEENS NORTH DEPOTS				
Casey Stengel	AGM-Depot Operations	Robert Ballas	(347) 694-1404	5067
QUEENS CENTRAL DEPOTS				
Jamaica	AGM-Depot Operations	Kenneth Bryant	(718) 658-6124	5108
Queens Village	AGM-Depot Operations	Robert Rogers	(347) 694-2175	5195
QUEENS SOUTH DEPOTS				
East New York	AGM-Depot Operations	Ronald Ethridge	(718) 566-3092	806
Fresh Pond	AGM-Depot Operations	Steve Lopiano	(718) 334-8641	5103

POST ON ALL BULLETIN BOARDS

NEW YORK CITY TRANSIT
DEPARTMENT OF SUBWAYS
OFFICE OF SENIOR VICE PRESIDENT

DATE: **July 18, 2014**

TO: **All Subways Employees**

FROM: **Sally Librera, Vice President & Chief Officer, Operations Support**

SUBJECT: **SUBWAYS BULLETIN 14-23**
TWU LOCAL 100 MATERNITY/PATERNITY LEAVE BENEFIT

Effective May 21, 2014, employees who are members of TWU, Local 100 are entitled to a two-week paid Maternity/Paternity Leave benefit subject to the following guidelines:

- Maternity/Paternity leave benefit is only effective for births or adoptions that occur on or after May 21, 2014.
- Maternity/Paternity leave is effective upon the birth or adoption of a child.
- Employees are entitled to two (2) weeks fully paid Maternity/Paternity Leave.
- Maternity/Paternity leave will be paid at run pay.
- Maternity/Paternity leave is treated as a 10-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, in person or by telephone, to their respective crew reporting center, assignment, control, car and time desk of their intention to be absent from work due to Maternity/Paternity Leave.

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

Email:	*SubwaysFMLA@nyct.com*
Phone:	(718) 694-3070
Fax:	(718) 694-5363
E-fax:	(646) 252-6505
Inter-office/USPS Mail	**Subways FMLA Unit,** 130 Livingston Street, 6th Floor Brooklyn, NY 11201

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

Attachment

cc: J. Leader, J. Bromfield, M. Brown, J. Gaito, J. Gaul, W. Habersham, Office of the VP & Chief Officer, SIR, R. Bergen, C. Johnson, J. Samuelsen (TWU)

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 _____ 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) TWU Local 100 5/21/14 MOU Sec 14-H
(Check or Insert Proper Rule No.)

From _____ to _____, inclusive, being

10 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 TWU 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)

_____, _____ Title, _____ 20____

_____, _____ Title, _____ 20____

_____, _____ Title, _____ 20____

_____, _____ Title, _____ 20____

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

Remarks: **RTO CREW ASSIGNMENT OFFICIAL DATE AND TIME: 12/4/2013 4:30:02 PM**

ORIGINAL to PERSONNEL DIRECTOR

FMLA Application Package

Birth of Child, Adoption or Foster Care

Departmental - FMLA Supplemental Information Form

Employee Completes and submits to FMLA Unit

If the leave is for Married Father, submit Marriage Certificate

If the leave is for Unmarried Father, must submit a copy of the Proof of Paternity from the Hospital

If the leave is for Adoption or Foster Care placement, Proof of adoption or Foster care placement, such as court papers or other official records will be required.

HR BEN 028 – FMLA Application

Employee Completes and submits to FMLA Unit

Departmental – Medical Proof of Pregnancy

Employee can submit original letter (on physician's letterhead) from "birth mother's" Physician stating Expected Date of Delivery

Employee's FMLA Rights and Responsibility

Employee's FMLA Procedure

MTA New York City Transit Authority
Operations Support – Employee Availability- (RTO & STA)
Family Medical Leave (FMLA) – Employee Guidelines

FMLA eligibility is based on the following criteria:

- One full year & minimum of 1250 actual work hours preceding actual request date
- Additionally, if it is a renewal application, you must have available FMLA days

FMLA Leave Time is entitlement as follows:

- FMLA Leave can be requested as Intermitted or Continuous
- FMLA Leave provides up to 60 Work Days or 12 Weeks Continuously in a rolling year
- FMLA Military Leave (Health) provides up to 26 Weeks in a single 12 month period
- FMLA Qualifying Military Exigency provides up to 12 weeks.

After Submitting an FMLA Request Application:

1. You will receive a letter from the MTA Business Service Center (BSC) concerning your eligibility status (either you are eligible or you are not eligible).
2. You will receive an "Approval" or Disapproval letter from the BSC after your Medical Certification is reviewed by the Medical Department (OHS).
3. You may begin your FMLA leave on the date you specified on your application if you have received an Approval letter. If you have not received an approval letter and your requested date to begin is approaching within 5 days call (718) 694-3070 to inquire.

Call Out Procedures – Always make two (2) calls to ensure FMLA absence

- Call your crew reporting center (OSAC or CREW office) or Office Manager/Supervisor
  - You must state you are calling out FMLA
    - **For Family Member** – state mother, father, spouse, daughter, son
    - **For Yourself** – must state symptom or body part (aka headache or head)

- Call the FMLA Desk (718) 694-3070
  - State your Name, Pass #, Title, RDOs
  - State the complete date you are taking FMLA (Month, day and year)
  - State whom the FMLA is for (child, spouse, parent, yourself)
  - State which type of leave you are requesting (AVA, VAC Days, PLD, OTO)

Leave Usage

- **FMLA For Family Member**
  - **You must use any leave balance other than sick (except managers)**
  - Your request must be in writing (for absences 5 days or less), print your name, pass # and sign then faxed request the same day to (718) 694-5363.
  - You must state the days of the request and what type of leave you want to apply, for example: Monday, March 11, 2013 Apply one (1) AVA
  - When you have requested to break up a week's vacation, you must state the vacation week #.

Employee's Responsibility for Family Member

- **For all requests exceeding 5 days, especially "out of state request", employee must submit a "Request for Leave other than Sick form"**
- **Copies of Plane tickets**
- **For emergency leaves, a letter from family members physician stating where the family member is hospitalized (with date or entry) or Care Facility (date of entry) or a viable substitute proving emergency (consult with FMLA Coordinator).**
- **You may be required to submit proof upon your return (please consult with FMLA Coordinator)**

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

***Special hours of service eligibility requirements apply to airline flight crew employees.**

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

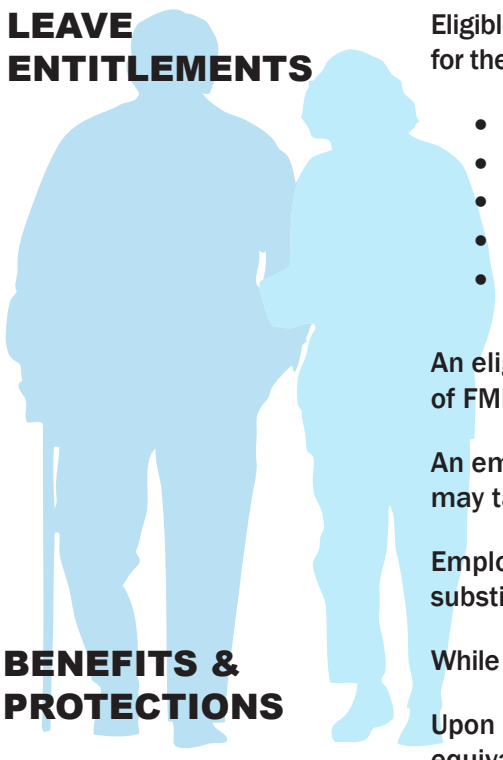
Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION



LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

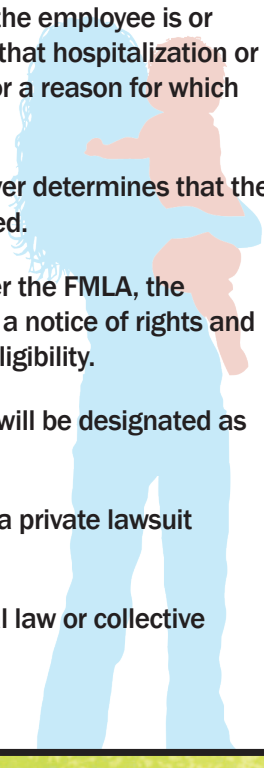
*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.



EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

WH1420 REV 04/16

New York City Transit
Department of Subways/Division of Operations Support
Employee Availability FMLA Supplemental Information

CONTACT INFORMATION:
130 Livingston Street, 6th Floor
(718) 694-3070 (FMLA Desk)
(718) 694-5363 (Fax)

EMPLOYEE INFORMATION					
Last Name		**First**		**M.I.**	**Date**
Pass No.		**BSC ID**			
Is this your first FMLA Application?	YES ☐	NO ☐	**If no, date of last application?**		
Do you need FMLA in less than 30 days?	YES ☐	NO ☐	**If yes, reason & date:**		

JOB INFORMATION		
Title:	**Job #:**	**RC #:**
Tour of Duty	**Location:**	**RDO:**
Manager's/Supervisors Name: *(Mow/CED)*		

DOCUMENTATION REQUIRED FOR LEAVE – FOR FAMILY MEMBER

If the reason for FMLA is for **other than yourself**, **you must provide proof of relationship**; this may include but not limited to marriage license, court documents for adoption, foster care, guardianships, birth certificates, affidavit, military: active duty orders, or as deemed appropriate.

From:	**To:**	**Care for Spouse** ☐ **Care for Child** ☐ **Care for Parent** ☐ **Military Exigency** ☐

Third Party Full Name:

Proof of Relationship Document submitted:

Third Party's Residence – (including) City, State, County and/or Country:

If you are traveling out of State or the Country, please indicate dates, place and provide copy of travel documents:

EMERGENCY CONTACT			
Name:		**Relationship:**	
Primary Phone:		**Cell Phone:**	

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge. I understand that false or misleading information in my application may result in the denial of FMLA. I further understand that processing of my application cannot occur if required proof of relationship documents is not submitted with my FMLA application.

Signature:		**Date:**

FMLA REPRESENTATIVE RECEIPT OF APPLICATION & DOCUMENTATION

Print Name: _____ Signature _____ Date _____

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) including absences related to a COVID-19 school or childcare facility closure.

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:

- NYCT/MTA Bus employees: Mail, email, or fax this form to your Agency FMLA Coordinator. Email questions to FMLASupport@nyct.com (DO NOT send the form to this mailbox).
- All other MTA Agency employees: Mail, email, or fax to your Agency Human Resources Department or FMLA Coordinator.
- 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 FOR A MEDICAL CONDITON or the COVID-19 CHILDCARE Request Form.

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

e) HR-BEN-929 COVID-19 Childcare Documentation Form

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 6) School or Childcare closure related to COVID-19. 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	Pass # (NYCT/MTA Bus)
Agency/ Dept (check one)	☐ BSC	☐ B&T	☐ C&D	☐ 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 provide care for my child/dependent because of a COVID-19 School or Childcare Facility Closure	
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 – COVID-19 Childcare Reason	
You must also complete the HR-BEN-929 form to claim this benefit	
Child's Name & Date of Birth	Relation to Employee
Name and address of School/Childcare Institution	Date of COVID-19 Closure

Section 5 – Request for Leave	
Leave Start Date	Leave End Date

Section 6 – 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 7 - 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 8 – 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.**

****For COVID-19 Childcare requests submit this form and HR-BEN-929 Childcare documentation form according to the instructions in Section 1. DO NOT submit to the contacts below.**

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** Hum an 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 Hum an 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 Application Package
Employee's Own Health Condition

Departmental - FMLA Supplemental Information Form

Employee Completes and submits to FMLA Unit

HR BEN 028 – FMLA Application

Employee Completes and submits to FMLA Unit

HR Ben 069 – Medical Certification

Employee completes Section I

FMLA Unit Completes Section II

Employee's Physician completes Section III

Employee's FMLA Rights and Responsibility

Employee's FMLA Procedure

New York City Transit
Department of Subways/Division of Operations Support
Employee Availability FMLA Supplemental Information

CONTACT INFORMATION:
130 Livingston Street, 6th Floor
(718) 694-3070 (FMLA Desk)
(718) 694-5363 (Fax)

EMPLOYEE INFORMATION					
Last Name		**First**		**M.I.**	**Date**
Pass No.		**BSC ID**			
Is this your first FMLA Application?	YES ☐	NO ☐	**If no, date of last application?**		
Do you need FMLA in less than 30 days?	YES ☐	NO ☐	**If yes, reason & date:**		

JOB INFORMATION		
Title:	**Job #:**	**RC #:**
Tour of Duty	**Location:**	**RDO:**
Manager's/Supervisors Name: *(Mow/CED)*		

DOCUMENTATION REQUIRED FOR LEAVE – FOR FAMILY MEMBER

If the reason for FMLA is for **other than yourself**, **you must provide proof of relationship**; this may include but not limited to marriage license, court documents for adoption, foster care, guardianships, birth certificates, affidavit, military: active duty orders, or as deemed appropriate.

From:	**To:**	**Care for Spouse** ☐ **Care for Child** ☐ **Care for Parent** ☐ **Military Exigency** ☐

Third Party Full Name:

Proof of Relationship Document submitted:

Third Party's Residence – (including) City, State, County and/or Country:

If you are traveling out of State or the Country, please indicate dates, place and provide copy of travel documents:

EMERGENCY CONTACT			
Name:		**Relationship:**	
Primary Phone:		**Cell Phone:**	

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge. I understand that false or misleading information in my application may result in the denial of FMLA. I further understand that processing of my application cannot occur if required proof of relationship documents is not submitted with my FMLA application.

Signature:		**Date:**

FMLA REPRESENTATIVE RECEIPT OF APPLICATION & DOCUMENTATION

Print Name: _____ Signature _____ Date _____

Family and Medical Leave Act Request Form

HR-BEN-028

Section 1 - Information and Instructions

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- All other MTA Agency employees: Mail, email, or fax to your Agency Human Resources Department or FMLA Coordinator.
- 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 FOR A MEDICAL CONDITON or the COVID-19 CHILDCARE Request Form.

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

e) HR-BEN-929 COVID-19 Childcare Documentation Form

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 6) School or Childcare closure related to COVID-19. 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	Pass # (NYCT/MTA Bus)
Agency/ Dept (check one)	☐ BSC	☐ B&T	☐ C&D	☐ 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 provide care for my child/dependent because of a COVID-19 School or Childcare Facility Closure	
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 – COVID-19 Childcare Reason	
You must also complete the HR-BEN-929 form to claim this benefit	
Child's Name & Date of Birth	Relation to Employee
Name and address of School/Childcare Institution	Date of COVID-19 Closure

Section 5 – Request for Leave	
Leave Start Date	Leave End Date

Section 6 – 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 7 - 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

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 II 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 II – Employee Information

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

Section III – For Completion by the 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 3.

Provider's Name	License number	State
Type of Practice/ Medical Specialty		
Provider's Address		
City	State	Zip Code
Telephone	Fax	

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

HR-BEN-069

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Mark below as applicable:
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ____Yes If so, dates 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: _____

3. Use the information provided in Section II 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):

   _____

   _____

   _____

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

HR-BEN-069

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time 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: _____

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 INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

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

MTA New York City Transit Authority
Operations Support – Employee Availability- (RTO & STA)
Family Medical Leave (FMLA) – Employee Guidelines

FMLA eligibility is based on the following criteria:

- One full year & minimum of 1250 actual work hours preceding actual request date
- Additionally, if it is a renewal application, you must have available FMLA days

FMLA Leave Time is entitlement as follows:

- FMLA Leave can be requested as Intermitted or Continuous
- FMLA Leave provides up to 60 Work Days or 12 Weeks Continuously in a rolling year
- FMLA Military Leave (Health) provides up to 26 Weeks in a single 12 month period
- FMLA Qualifying Military Exigency provides up to 12 weeks.

After Submitting an FMLA Request Application:

1. You will receive a letter from the MTA Business Service Center (BSC) concerning your eligibility status (either you are eligible or you are not eligible).
2. You will receive an "Approval" or Disapproval letter from the BSC after your Medical Certification is reviewed by the Medical Department (OHS).
3. You may begin your FMLA leave on the date you specified on your application if you have received an Approval letter. If you **have not received an approval letter** and your requested date to begin is approaching within 5 days call (718) 694-3070 to inquire.

Call Out Procedures – Always make two (2) calls to ensure FMLA absence

- **Call your crew reporting center (OSAC or CREW office)**
  - You must state you are calling out FMLA
    - **For Family Member** – state mother, father, spouse, daughter, son
    - **For Yourself** – must state symptom or body part (aka headache or head)

- **Call the FMLA Desk (718) 694-3070**
  - State your Name, Pass #, Title, RDOs
  - State the complete date you are taking FMLA (Month, day and year)
  - State whom the FMLA is for (child, spouse, parent, yourself)
  - State which type of leave you are requesting (AVA, VAC Days, PLD, OTO)

Leave Usage

- **FMLA For Family Member**
  - You must use any leave balance other than sick
  - Your request must be in writing, print your name, pass # and sign then faxed request the same day to (718) 694-5363.
  - You must state the days of the request and what type of leave you want to apply, for example: Monday, March 11, 2013 Apply one (1) AVA
  - When you have requested to break up a week's vacation, you must state the vacation week #.
- **FMLA for Your Own Health Condition**
  - Sick Leave Balances are applied first to all FMLA request
  - After Sick leave is exhausted
    - you can request Sick without Pay
    - you can request Vacation/AVA/OTO in lieu of sick

Employee's Responsibility

- **All MTA NYCT Sick Rules Apply – When FMLA is for your own Health Condition**
  - A **copy** of your sick form must be given to FMLA

DISABILITY CLAIM CHECKLIST

Policy #:

Your Policy has a 14-day elimination period which is a non-payable time frame. Please do not complete your claim forms until you have incurred this time.

*Please have **all** sections of the claim form completed in its entirety including the **HIPAA Authorization Form** and return with the **Claim Fraud Warning** statement and any additional information being requested below:*

☐ HOSPITAL DISCHARGE PAPERWORK

☑ ER DISCHARGE PAPERWORK

☑ INJURY ON DUTY REPORT

☐ COPY OF POLICE ACCIDENT REPORT

☐ G46 TAKING YOU OFF THE JOB

☐ OTHER:

Please return the Fraud Warning Statement

Any questions or concerns please do not hesitate to contact the office at:

877-456-3428

F: 833-300-0257

TRANSAMERICA

Supplemental Health

Transamerica Financial Life Insurance Company
Home Office: Harrison, New York
Transamerica Life Insurance Company
Transamerica Premier Life Insurance Company

Fax Number: 833-300-0257 Email: Service@m3tech.com

Instructions for Submitting a Claim

This Health Claim Package consists of multiple parts. When filling out each section of the package, please keep in mind that you should provide complete and accurate information. If you make a claim on your dependent who is over the age of 18, the claimant (patient) needs to sign and date the HIPAA Authorization for the Release of Health-Related Information ("HIPAA Authorization") – you cannot sign for the dependent. Take a moment, also, to verify that the doctor completing the Attending Physician's Statement answers all questions and signs and dates the form.

Here are some other common documents and statements needed when filing certain types of health claims. It's important to note that the list of forms and information within each claim type are generic. You should refer to your actual policy benefits to help determine what else you may need to submit to us for consideration.

Accident/Disability*
Claimant's Statement, Attending Physician's Statement (unless applying for accident medical expense benefits), HIPAA Authorization, Employer's/Business Entity's Statement, statement(s) showing actual charges/expenses for medical treatment or diagnosis, and a police report if the disability is a result of a motor vehicle accident. If the disability began with an emergency room visit, please provide us with a copy of the discharge summary; if the disability was an on-the-job accident, provide us with a first report of the injury.

Critical Assistance*
Claimant's Statement, Attending Physician's Statement, HIPAA Authorization, diagnostic reports (a pathology report if cancer-related), discharge summary or other medical records indicating the condition and date of diagnosis.

Cancer*
Claimant's Statement, Attending Physician's Statement, HIPAA Authorization, along with a pathology report diagnosing cancer. Itemized provider statements with actual charges/expenses (**) incurred for the treatment.

Heart/Stroke**
Claimant's Statement, Attending Physician Statement, HIPAA Authorization, and all itemized hospital statements with actual charges/expenses incurred for the treatment.

Intensive Care/Hospital Indemnity
Claimant's Statement, Attending Physician's Statement, HIPAA Authorization, itemized hospital or UB04 statements, and ambulance statement if transported (ICU Coverage only).

*For Wellness Screening Benefit, you only need to submit statements or medical records from the physician or hospital showing the date and procedure performed. No additional documents are necessary.
**If you are covered by Medicare or Medicaid or other insurance, please submit statements from doctor/medical provider/hospital showing payments or adjustments by Medicare, Medicaid, or your other insurance. You also must send any other information showing the actual charges or expenses incurred for your treatment, which includes copies of all summary notices from Medicare or Medicaid, or explanations of benefits from your other insurance.

TRANSAMERICA

Supplemental Health Insurance Claim Form

Transamerica Financial Life Insurance Company
Home Office: Harrison, New York
Transamerica Life Insurance Company
Transamerica Premier Life Insurance Company

Administrative Office: P.O.Box 512 Matawan, NJ 07747
Fax: 833-300-0257 Email: Service@m3Tech.com

By furnishing this form, the Company does not admit that there is any insurance in force and does not waive any of its rights or defenses.

CLAIMANT'S STATEMENT

1. Insured's Full Name	2. Date of Birth	3. Policy or Certificate Number	4. Social Security Number
5a. Mailing Address			6. Phone Number
5b. Street Address			7. Email Address
8. Employer	9. Occupation		10. Work Phone Number
11. Patient's Full Name	12. Date of Birth		13. Relationship to Insured

ONLY COMPLETE THE INFORMATION THAT APPLIES TO YOUR LOSS

If additional space is needed for any question, please use an additional sheet of paper and attach to this form.

1. Nature of injury or illness	2. Have you previously had this same or similar condition? ☐ Yes ☐ No If yes, give date:
3. When did symptoms first appear or accident occur? If an injury, explain fully how and where accident occurred.	4. Date first treated/diagnosed
5. Name and address of physician (list all physicians consulted)	
6. Do you have Medicare? ☐ Yes ☐ No Do you have Medicaid? ☐ Yes ☐ No Do you have other health insurance? ☐ Yes ☐ No If yes, what company?	
7. Have you been confined to a hospital for this condition? ☐Yes ☐No Admission date: Discharge Date:	8. Please give name and address of hospital.
9. Were you confined in an Intensive Care Unit during this hospital stay? ☐ Yes ☐ No If yes, for how many days?	10. If you had surgery, please give the name and address of the surgeon
11. If you were unable to work due to this condition, please give dates. From To	12. If you were restricted to light duty due to this condition, please give dates. From To
13. When do you expect to resume your usual duties?	14. Are you filing a Workers' Compensation claim? ☐ Yes ☐ No
15. If applying for waiver of premium, give dates of total disability. From To	16. Have you ever been treated for or diagnosed as having had a heart attack, heart trouble or any abnormal condition of the heart; cancer; or diabetes prior to the effective date of this policy? ☐ Yes ☐ No If yes, provide condition and date?_____.
17. Please give the name and address of the physician and/or hospital who treated you for this the condition in box 16.	

Please continue onto next page

If you are filing for disability benefits as a result of an accident or sickness, please complete this section and have the attached Employer's Business Entity Statement completed by your employer

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

Salary Continuance/Sick Leave ☐ Yes ☐ No If "Yes," indicate number of hours as of last date worked _____

EIB/PTO ☐ Yes ☐ No If "Yes," indicate number of hours as of last date worked _____

	Applied For	Receiving	Amount	Frequency	From/To Dates
Short Term Disability	☐	☐	$_____	_____	_____/_____
Worker's Compensation	☐	☐	$_____	_____	_____/_____
State Disability	☐	☐	$_____	_____	_____/_____
Social Security	☐	☐	$_____	_____	_____/_____
Dependent Social Security	☐	☐	$_____	_____	_____/_____
No Fault (Income Replacement)	☐	☐	$_____	_____	_____/_____
Retirement/Pension	☐	☐	$_____	_____	_____/_____
Permanent Total Disability	☐	☐	$_____	_____	_____/_____
Other (Please Identify	☐	☐	$_____	_____	_____/_____

All must sign and date below.

All of the above answers and statements are true and complete, and correctly recorded. I have read and understand the appropriate Fraud Warning. I understand that the furnishing 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 Signature

_____

Print Name

_____

Date (mm/dd/yyyy)

Fax Number: 833-300-0257

ATTENDING PHYSICIAN'S STATEMENT			
1. 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	Are you being paid by Medicaid? ☐ Yes ☐ No	Are you being paid by other health insurance? ☐ Yes If yes, what company? ☐ No	
6. Diagnosis? (Please use ICD 10 Codes)	7. When did symptoms first appear or accident happen?	8. When did the patient first consult you for this condition?	9. Is this condition work related? ☐ Yes ☐ No
10. If the patient previously received medical treatment, please provide the physician's/hospital's name and address.			
11. If the claim is for pregnancy, please give due date and type of delivery.		12. Has the patient ever had the same or similar condition? ☐ Yes ☐ No (If yes, state when and describe)	
13. Describe any other disease or infirmity affecting present condition.		14. List surgical procedure(s), if any, and include the date of the procedure(s). (Please use current CPT codes.)	
15. List the dates of treatment and the charges for each visit.		16. If the patient was hospitalized, please give the name and address of the hospital and dates of confinement.	
17. Is the patient still under your care for this condition? ☐ Yes ☐ No If discharged, please give date _____		18. If the patient has been referred to another physician, please give the name and address.	
19. Did you advise patient to cease work? ☐ Yes ☐ No If yes: From To		20. Please give dates of total disability for this condition. From To	
21. If the patient was released to light duty due to this condition, please give dates. From To		22. Was the patient unable to perform two or more ADL's (Activities of Daily Living) due to this condition? ☐ Yes ☐ No If so, which ones?	
23. Has patient ever been treated for a heart attack, heart trouble or any abnormal condition of the heart; cancer; or diabetes prior to this time? ☐ Yes ☐ No If yes, please advise when and name and address of doctor/hospital treating patient.			
24. Please list conditions and corresponding dates for which you previously treated this patient within the past five years.			

Date	Physician's Name – Print	Signature	Degree	Phone Number ( )

Street address	City	State	Zip	Tax Identification Number

TRANSAMERICA

Transamerica Financial Life Insurance Company
Home Office: Harrison, New York
Transamerica Life Insurance Company
Transamerica Premier Life Insurance Company
Claims Fax: 833-300-0257
Claims Email: Service@m3tech.com
Claims Customer Service: 877-456-3428

If you are filing for disability benefits as a result of an accident or sickness, have the below completed by your employer.

Employer's/Business Entity's Statement (Does not apply to Cancer, Hospital and Critical Illness coverages)

1. Company Name:			2. Phone Number:
3. Street Address:	4. City:	5. State:	6. Zip Code:
7. Name of Employee/Insured Person:	8. Social Security Number:		

9. IMPORTANT: date Employee/insured person was last actively at work:

10. Employee's/Insured Person's job title/major job duties **(Please 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. Date employee/insured person returned to work: _____
☐ Full Time ☐ Part Time ☐ Light Duty

13. If "Part Time", due to partial disability, provide earnings:
Amount: _____ From/To Dates: _____

14. Employee/Insured Person's status of employment after first day absent:
☐ Active ☐ Leave of Absence ☐ Laid Off ☐ Retired ☐ Terminated Other: _____

15. Employee/Insured Person's **current** status of employment:
☐ Active ☐ Leave of Absence ☐ Laid Off ☐ Retired ☐ Terminated Effective: _____

16. Annual Salary $ _____

17. If employee was medically cleared to return to work with restrictions or on light duty can you accommodate? ☐ Yes ☐ No
If no, please attach a letter stating why accommodation is not possible.

18. To the best of your knowledge, indicate if employee/insured person has filed for or is receiving income from any of the following sources:

Salary Continuance/Sick Leave	☐ Yes	☐ No	If "Yes," indicate number of hours as of last date worked _____
EIB/PTO	☐ Yes	☐ No	If "Yes," indicate number of hours as of last date worked _____
Workers Compensation	☐ Yes	☐ No	

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

Employer's/Business Entity's Authorized Representative

Name (please print) _____ Title _____ Phone # _____

Signature _____ Date _____

Claim Fraud Warning

State Specific Notices:

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, Rhode Island, 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 an 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: 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.

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 Mexico: 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.

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 who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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.

Oregon: Any person who knowingly and with intent to defraud an insurance company files an application for insurance or statement of claim containing any materially false information may be guilty of insurance fraud. To deny a claim on the basis of misstatements, misrepresentations, omissions or concealments, the misinformation must be material to the content of the policy, the insurer must rely upon the misinformation and the misinformation must be either material to the risk assumed by the insurer or provided fraudulently. For remedies other than denial of a claim, misstatements, misrepresentations, omissions or concealments must either be fraudulent or material to the interests of the insurer in order for the insurer to assert a right to remedy. Misstatements, misrepresentations, omissions or concealments are not fraudulent unless they are made with the intent to knowingly defraud.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Texas: Any person who knowingly presents a 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

FOR RESIDENTS OF ALL OTHER STATES AND TERRITORIES: Any person who knowingly, and with intent to injure, defraud or deceive 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.

TRANSAMERICA®

HIPAA Authorization for Release of Health- Related Information

Transamerica Financial Life Insurance Company
Home Office: Harrison, New York
Transamerica Advisors Life Insurance Company
Transamerica Life Insurance Company
Transamerica Premier Life Insurance Company

This authorization complies with the HIPAA Privacy Rule.
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 company(ies) referenced at the top of this authorization (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. 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 also includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection 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 and I instruct the Providers to release and disclose the **entire medical record and any other protected health information as noted above** without restriction.

The information disclosed will be used for claims processing, including but not limited to evaluating contestability, eligibility determination, and/or benefit determinations.

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, 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. 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 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 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 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.

Name of insured/patient (please print)

Date of birth

Signature of Insured/Patient or Personal Representative of the Insured/Patient

Date

Description of Personal Representative's Authority or Relationship to Insured/Patient

Policy or Contract Number
(for use in Claims processing)

TRANSAMERICA®

Medical History Form

Transamerica Financial Life Insurance Company
Home Office: Harrison, New York
Transamerica Advisors Life Insurance Company
Transamerica Life Insurance Company
Transamerica Premier Life Insurance Company

Name of Insured	Social Security Number

Policy Number(s)

Please list below the names, addresses, and phone numbers of all medical providers, including doctors and hospitals, consulted or used by the insured for the following dates, beginning _____ through _____.
If more space is needed, please attach additional pages to this form.

Primary/ Family Physician	Phone Number

Street Address	City	State	Zip Code

Reason for Visit	Dates Consulted or Year Treated

Provider Name	Phone Number

Street Address	City	State	Zip Code

Reason for Visit	Dates Consulted or Year Treated

Provider Name	Phone Number

Street Address	City	State	Zip Code

Reason for Visit	Dates Consulted or Year Treated

Name of Insured	Policy Number(s)

Provider Name	Phone Number

Street Address	City	State	Zip Code

Reason for Visit	Dates Consulted or Year Treated

For the dates listed on page 1, the following prescriptions have been filled for the insured (see label on Rx bottle). If more space is needed, please attach additional pages to this form.

Medication Name	Condition Being Treated	Prescribing Physician Name

Name/ Address of Pharmacy

Medication Name	Condition Being Treated	Prescribing Physician Name

Name/ Address of Pharmacy

Medication Name	Condition Being Treated	Prescribing Physician Name

Name/ Address of Pharmacy

Medication Name	Condition Being Treated	Prescribing Physician Name

Name/ 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

Memorandum

New York City Transit

Date: April 5, 2007

To: TWU, Local 100 Represented Employees

From: MTA New York City Transit

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

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

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

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

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

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

General Guidelines for SHORT TERM DISABLITY (STD)

Package:

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

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

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

Basic Rules:

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

Employee's Responsibility:

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

Timekeeper's Responsibility:

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

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

CLAIMANT: READ THE FOLLOWING INSTRUCTIONS CAREFULLY

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

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

Social Security Number

1. Name _____ (First / Middle / Last)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CLAIM SIGNED ON: _____
DATE CLAIMANT'S SIGNATURE

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

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

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

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

PART B – HEALTH CARE PROVIDER'S STATEMENT

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

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

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

4. Diagnosis / Analysis: _____ Diagnosis Code: _____

a. Claimant's Symptom's: _____

b. Objective Findings: _____

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

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

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

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

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

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

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

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

Remarks: _____

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

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

Health Care Provider's Signature _____ Date _____

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

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

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

INSTRUCTIONS:

1 Claimant completes PART A

2 Health Care Provider completes PART B

KEEP A COPY FOR YOUR RECORDS

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

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

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

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

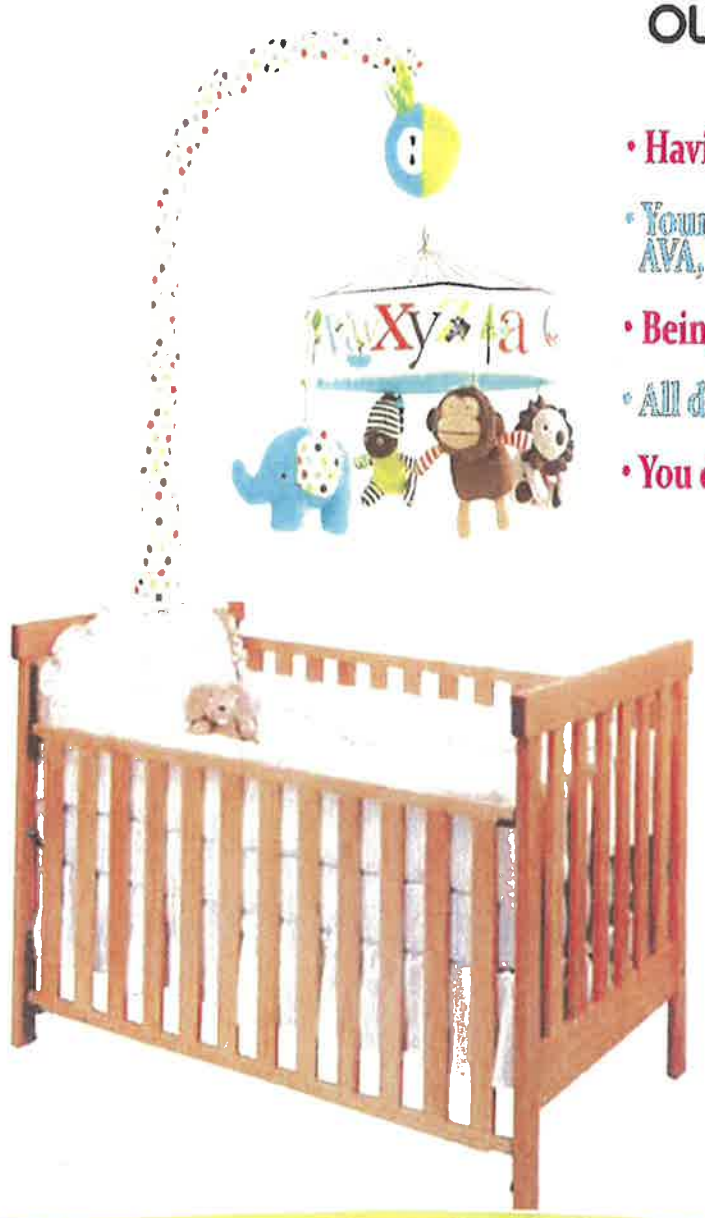
Division	Responsible Unit	Contact Person	Telephone
Department of Subways			
Car Equipment	Central Timekeeping	Robert Mesnard	(718)694-1141
Track	MOW Timekeeping	Beverly Marks	(718)694-4921
Infrastructure	MOW Timekeeping	Beverly Marks	(718)694-4921
Electrical/Signals	MOW Timekeeping	Beverly Marks	(718)694-4921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

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

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

TWU Local 100-MTA/NYCTA
Childcare Fund

Newborn Stipend Voucher Program



OUR REQUIREMENTS INCLUDE:

- Having a Newborn child up to a year old
- Your leave time balances have to be at zero consecutively AVA, Vacation, Sick, and PLD)
- Being out of work unpaid
- All documents submitted to us must be originals
- You do not need to pass your one year probation to apply

Benefit is $200/week
up to 4 weeks

Please contact our office for additional details.

TWU Local 100- NYCTA Child Care Fund
195 Montague Street, 4th Floor, Brooklyn, NY 11201
Phone: (718) 780- 8700 Fax: (718) 222-1316
www.twulocal100ccf.org
E-mail: childcarefund@twulocal100ccf.org
Nicole Hecker, Acting Director