



# Metro

## SUPPLEMENTAL INSURANCE ACCIDENT & SICKNESS (A&S) BENEFITS

Metro provides Division 788 A.T.U. Operations, Maintenance and Clerical employees income protection in the event an employee is absent from work due to a non-occupational injury or illness, which renders the employee unable to perform the essential functions of their occupation.

**This benefit is not available to IBEW employees and Van Operators.**

**Eligible Classes**

**Class I: Division 788, A.T.U. (Operations & Maintenance)**

**Class II: Division 788, A.T.U. Clerical Unit**

**Eligibility Date:**

**Class I:** After seventy-five (75) calendar days of full-time employment provided the employee was actively at work on their normal Eligibility Date.

Coverage for employees not actively at work on their Eligibility Date will be delayed until they have completed seventy five (75) days of service.

**Class 2:** After seventy (75) days of full-time employment provided the employee was actively at work on their normal Eligibility Date.

Coverage for employees not actively at work on their Eligibility Date will be delayed until they have completed ninety (90) days of service.

**Benefit Level**

	Daily <u>Benefit</u>	Weekly <u>Rate</u>	<u>Maximum Duration</u>
Class I:	\$30.00	\$210.00	75 days per calendar year
Class II:	\$30.00	\$210.00	75 days per calendar year

Upon exhausting the Maximum Duration of Benefits, employees may not receive any additional benefits unless the employee has returned to work for four (4) consecutive weeks.

**Period of Disability** All disability absences due to the same or related causes will be considered to be the same period of disability unless the absences are separated by at least four (4) weeks of full-time work.

**Benefit Commencement** Benefits will begin on the eighth consecutive day. The employee must have depleted all accumulated sick leave.

**Conditions of Payment**

- 1) The Period of Disability must begin while the employee is covered under these provisions; and,
- 2) The employee must be under the regular care of a licensed physician; and
- 3) Medical documentation to support the claim for Supplemental A&S Benefits must be provided to the employee's supervisor every two weeks throughout the Period of Disability. If the employee fails to provide re-certification when requested by the Agency, the employee's A&S benefit will cease.

**Filing a Claim** Provided it is reasonably possible to do so, the initial claim must be submitted to an employee's supervisor within sixty (60) days from the Benefit Commencement Date but not more than ninety (90) days. Claim forms can be obtained from an employee's supervisor or by contacting the Benefits Section at (314) 923.1400 extension 3006.

**Payment**

The Agency's Payroll Section processes Supplemental Benefits. Payments are processed weekly and generally cover a period that precedes the check date by two (2) weeks.

**General Information**

- (1) Supplemental A&S Benefits are not assignable.
- (2) The Agency reserves the right to request an independent medical examination of its choice at the Agency's expense.

# Exhibit 1

## BI-STATE DEVELOPMENT AGENCY SUPPLEMENTAL ACCIDENT & SICKNESS BENEFITS

IF AN EMPLOYEE APPLIES FOR SUPPLEMENTAL ACCIDENT & SICKNESS BENEFITS  
DUE TO A HEALTH CONDITION COVERED BY THE FAMILY AND MEDICAL LEAVE ACT (FMLA) OF 1993,  
THE PERIOD OF ACCIDENT & SICKNESS LEAVE WILL ALSO APPLY TO THE EMPLOYEE'S  
ANNUAL FMLA ENTITLEMENT

### SECTION A EMPLOYEE'S STATEMENT

Employee's name	Social Security No.	Badge
Address	City	State Zip
Phone Number	I hereby authorize the treating physician(s) to release any information necessary to complete my verification of illness or injury.	
	Employee's Signature	Date

### SECTION B TREATING PHYSICIAN'S REPORT

Patient's Name	Date of Examination
IS PATIENT UNABLE TO WORK? YES _____ NO _____	
IF YES, DATE FROM WHICH EMPLOYEE IS UNABLE TO WORK ____/____/____	DATE EMPLOYEE IS ABLE TO RETURN TO UNLIMITED DUTY ____/____/____
DIAGNOSIS & CURRENT CONDITIONS:	_____
_____	_____
Physician's Name	
Address	City State Zip
Physician's Signature	Phone No.

### SECTION C SUPERVISOR'S APPROVAL

Supervisor's Signature	Date
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**INSTRUCTIONS**  
Employee must complete and sign SECTION "A"  
Treating physician must complete and sign SECTION "B"  
Supervisor must approve application for supplemental benefits SECTION "C"  
and forward to the Benefits Department