Transit Employees'

HEALTH AND WELFARE PLAN

metro

2701 WHITNEY PLACE • SUITE 100 • FORESTVILLE, MARYLAND 20747
PHONE: (301) 568-2294 • FAX: (301) 568-7302
WEBSITE: http://tehw.org • EMAIL: info@tehw.org

RE: Short Term Disability Benefits

Dear Member:

You requested a Short-Term Disability (STD) application packet because you expect to be off from work more than 30 days and your sick leave is exhausted. Therefore, you may be eligible for payment of STD benefits, if you were enrolled in the Health & Welfare Plan on your last day worked and are still enrolled.

To apply for benefits, please return the following enclosed forms to the Health & Welfare office.

Application for STD Benefits to be completed and signed by the applicant.

Physician Disability Certificate to be completed and signed by your attending physician.

Federal and State Tax withholding forms to be completed and signed by the applicant.

Direct Deposit form *(attach VOID check)* to be completed and signed by the applicant.

We will process your claim after receipt of the above-completed forms in this office and after we have confirmed your last paid sick day. If you are eligible for benefits, your first check will be retroactive to your initial date of eligibility. Subsequent checks will be issued weekly for one hundred seventy dollars ($170.00) per week for normal disability, or two hundred seventy dollars ($270.00) for maternity leave. We will take deductions for Federal and State taxes and partial premiums for Health & Welfare coverage. Payments will continue until you return to work or retire, but in no case will they continue longer than 26 weeks. We mail STD checks weekly to the address provided on the application unless you choose direct deposit. However, direct deposits begin on the second payment.

You will be required to furnish this office with **an updated Physician Certificate once a month** or when requested. Failure to return the requested Certificate will result in suspension of payments until the Certificate is received in the Health & Welfare office.

Health & Welfare premiums will be deducted from your STD benefits check including any delinquency. We will deduct any remaining balance from your paycheck upon returning to work or long-term disability payments.

By signing the application, you agree that the Transit Employees' Health and Welfare Fund has the right to collect any overpayments made for any reason.

If you have any questions regarding your application for short-term disability benefits, please contact the Health & Welfare office, Monday through Friday from 9:00 A.M. to 4:30 P.M.

(Enclosures)

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APPLICATION for SHORT-TERM DISABILITY BENEFITS from the TRANSIT EMPLOYEES' HEALTH & WELFARE FUND

Employee Name _____

Last 4 of SSN _____ Payroll Number _____

Date of Birth _____ Last Day Worked _____

Days Off Work *(check two days):* ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun

Supervisor Name _____ Supervisor Tel No _____

Supervisor Email _____ Dept./Division _____

Short-Term Disability Benefits are weekly payments for non-occupational injury or illness which begins after 30 days of disability or exhaustion of paid sick leave, whichever occurs later. If your injury or illness is job-related and you were denied Workers' Compensation, but you plan to appeal the decision, you must provide the Fund with additional documentation to complete this application.

Is this Injury or Illness job-related? ☐ Yes ☐ No *(if No checked, skip the next section)*

When did you apply for Workers' Compensation benefits? _____

When were you denied Workers' Compensation benefits? _____
(Provide a copy of the Denial letter)

If payments were started and then stopped, provide the start and stop dates.
Start _____
Stop _____

Have you or do you plan to appeal the denial? ☐ Yes ☐ No *(If yes, provide a copy of the letter)*

Have you been Medically Disqualified from working by Occupational Health & Wellness? ☐ Yes ☐ No *(If yes, provide a copy of the letter)*

I certify that this illness or injury **is not** the result of:

1. Services in the armed forces of the United States or any other nation
2. Performance of duties for another employer while on authorized leave from WMATA
3. Use of intoxicants, narcotics or criminal misconduct. (EAP volunteers excluded)
4. Work-related injury or illness

By submission of this application, my initials and my signature, I authorize:

1. Health & Welfare premium payments to be deducted from weekly disability checks, if applicable. ***Initial*** _____
2. Repayment of any weekly disability overpayments and health & welfare premium contributions through payroll deductions when I return to duty. ***Initial*** _____

Signature _____

Address _____

_____

Phone Number _____ ☐ Home ☐ Cell

Alternate Phone Number _____ ☐ Home ☐ Cell

Email _____ Date _____

Please return this form to: Transit Employees' Health & Welfare Office
2701 Whitney Place, Suite 100
Forestville, MD 20747-2347

If you have any questions regarding your benefits, please call Ashley Wade at 301-568-2294 Monday – Friday from 9:00 am – 4:30 pm.

Transit Employees'

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HEALTH AND WELFARE PLAN

2701 WHITNEY PLACE • SUITE 100 • FORESTVILLE, MARYLAND 20747-3457
PHONE: (301) 568-2294 • FAX: (301) 568-7302
WEBSITE: http://tehw.org • EMAIL: info@tehw.org

PHYSICIAN DISABILITY CERTIFICATION

THIS CERTIFICATE MUST BE COMPLETED AND SIGNED BY THE ATTENDING PHYSICIAN OF THE MEMBER APPLYING FOR WEEKLY BENEFITS

I hereby certify that _____ has been inclusively under my professional care from _____ 20_____ to _____ 20_____. During this entire period he/she was unable to perform his/her regular duties.

Diagnosis Code: ICD9 ❑ ICD10 ❑	Diagnosis:

If maternity, expected due date _____.

He/She will be able to return to his/her regular duties as a _____ on _____.

_____
Attending Physician's Original Signature (NO STAMP)

_____
Physician's Name (Print)

_____
License or Reg. Number

_____
Address

_____
City State Zip Code

_____ _____
Date (Area Code) Telephone Number

PLEASE RETURN THE ORIGINAL DOCUMENT

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▶ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
▶ **Give Form W-4 to your employer.**
▶ **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2022

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		▶ **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying widow(er)**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . ▶ ☐

TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ▶ $ _____

Multiply the number of other dependents by $500 . . . . ▶ $ _____

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

▶ _____ **Employee's signature** (This form is not valid unless you sign it.) ▶ _____ **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

Government of the District of Columbia

2018 D-4 DC Withholding Allowance Certificate

Taxpayer identification number (TIN) See instructions.

First name M.I. Last name

Home address (number, street and suite/apartment number if applicable)

City State Zip code +4

1 Tax filing status (Fill in only one) ○ Single ○ Married/domestic partners filing jointly/qualifying widow(er) with dependent child
○ Head of household ○ Married filing separately ○ Married/domestic partners filing separately on same return

2 Total number of withholding allowances from worksheet below.

Enter total from Sec. A, Line i **Enter total from Sec. B, Line m** **Total number of withholding allowances , Line n**

3 Additional amount, if any, you want withheld from each paycheck

4 Before claiming exemption from withholding, read below. If qualified, write "EXEMPT" in this box. ▶

5 My domicile is a state other than the District of Columbia Yes No If yes, give name of state of domicile _____

I am exempt because: last year I did not owe any DC income tax and had a right to a full refund of all DC income tax withheld from me; and this year I do not expect to owe any DC income tax and expect a full refund of all DC income tax withheld from me; and I qualify for exempt status on federal Form W-4.

If claiming exemption from withholding, are you a full-time student? Yes No

Signature Under penalties of law, I declare that the information provided on this certificate is, to the best of my knowledge, correct.

Employee's signature Date

Employer Keep this certificate with your records. If 10 or more exemptions are claimed or if you suspect this certificate contains false information please send a copy to: Office of Tax and Revenue, 1101 4th St., SW, Washington, DC 20024 Attn: Compliance Administration

Detach and give the top portion to your employer. Keep the bottom portion for your records.

Government of the District of Columbia

D-4 DC Withholding Allowance Worksheet

Section A Number of withholding allowances

a	Enter 1 for yourself	a
b	Enter 1 if you are filing as a head of household	b
c	Enter 1 if you are 65 or over	c
d	Enter 1 if you are blind	d
e	Enter number of dependents	e
f	Enter 1 for your spouse or registered domestic partner filing jointly or filing separately on same return or if you are a qualifying widow(er) with dependent child	f
g	Enter 1 if married or registered domestic partner filing jointly or filing separately on same return and your spouse or registered domestic partner is 65 or over	g
h	Enter 1 if married or registered domestic partner filing jointly or filing separately on same return and your spouse or registered domestic partner is blind	h
i	Number of allowances Add Lines a through h, enter here and on Line 2 above, next to "Enter total from Sec. A, Line i".	i

If you want to claim additional withholding allowances, complete Section B below.

Section B Additional withholding allowances

j	Enter estimate of your itemized deductions	j
k	Enter $6,500 if single, married/registered domestic partners filing separately or a dependent. Enter $9,550 if head of household. Enter $13,000 if married/registered domestic partner filing jointly, married filing separately on the same return, or qualifying widow(er) with dependent child.	k
l	Subtract Line k from Line j	l
m	Divide Line l by $4,150. Round to the nearest whole number, enter here and on Line 2 above, next to "Enter total from Sec.B, Line m".	m
n	Add Lines m and i, enter here and on Line 2 above, next to "Total number of withholding allowances, Line n".	n

Revised 10/2017

Employee Direct Deposit Enrollment Form

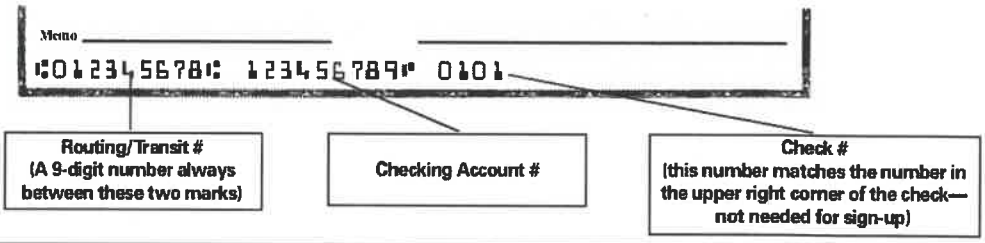
Payroll Manager—Please complete this section.

Company Code: _____ Company Name: _____ Date: _____

Payroll Mgr. Name: _____ Payroll Mgr. Signature: _____

To enroll in Full Service Direct Deposit, simply fill out this form and give it to your payroll manager. Attach a voided check for each checking account – not a deposit slip. If depositing to a savings account, ask your bank to give you the Routing/Transit Number for your account. It isn't always the same as the number on a savings deposit slip. This will help ensure that you are paid correctly.

Below is a sample check MICR line, detailing where the information necessary to complete this form can be found.



Important! Please read and sign before completing and submitting.

I hereby authorize my employer (hereinafter "Company") to deposit any amounts owed me by initiating credit entries to my accounts at the financial institutions (hereinafter "Bank") indicated on this form. Further, I authorize Bank to accept and to credit any credit entries indicated by Company to my accounts. Unless prohibited by applicable law, in the event that Employer deposits funds erroneously into my account, I authorize Employer, either directly or through its payroll service provider, to debit my account for an amount not to exceed the original amount of the erroneous credit.

This authorization is to remain in full force and effect until Company and Bank have received written notice from me of its termination in such time and in such manner as to afford Company and Bank reasonable opportunity to act on it.

Employee Name: _____

Employee Signature: _____ Date: _____

Account Information

The last item must be for the remaining amount owed to you. To distribute to more accounts, please complete another form.
Make sure to indicate what kind of account, along with amount to be deposited, if less than your total net paycheck.

1. Bank Name/City/State: _____

Routing/Transit #: _ _ _ _ _ _ _ _ _ Account Number: _____

☐Checking ☐ Savings ☐ Other I wish to deposit: $ _____ . ____ or ☐ Entire Net Amount

2. Bank Name/City/State: _____

Routing/Transit #: _ _ _ _ _ _ _ _ _ Account Number: _____

☐Checking ☐ Savings ☐ Other I wish to deposit: $ _____ . ____ or ☐ Entire Net Amount

3. Bank Name/City/State: _____

Routing/Transit #: _ _ _ _ _ _ _ _ _ Account Number: _____

☐Checking ☐ Savings ☐ Other I wish to deposit: $ _____ . ____ or ☐ Entire Net Amount

ATTENTION PAYROLL MANAGER:
Employers must keep each original employee enrollment form on file as long as the employee is using FSDD, and for two years thereafter.