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'

metro

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

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EN ______________

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)

FORM
MW507

Purpose. Complete Form MW507 so that your employer can withhold the correct Maryland income tax from your pay. Consider completing a new Form MW507 each year and when your personal or financial situation changes.

Basic Instructions. Enter on line 1 below, the number of personal exemptions that you will be claiming on your tax return; however, if you wish to claim more exemptions, or if your adjusted gross income will be more than $100,000 if you are filing single or married filing separately ($150,000, if you are filing jointly or as head of household), you must complete the Personal Exemption Worksheet on page 2. Complete the Personal Exemption Worksheet on page 2 to further adjust your Maryland withholding based upon itemized deductions, and certain other expenses that exceed your standard deduction and are not being claimed at another job or by your spouse. However, you may claim fewer (or zero) exemptions.

Additional withholding per pay period under agreement with employer. If you are not having enough tax withheld, you may ask your employer to withhold more by entering an additional amount on line 2.

Exemption from withholding. You may be entitled to claim an exemption from the withholding of Maryland income tax if:

a. last year you did not owe any Maryland Income tax and had a right to a full refund of any tax withheld; AND

b. this year you do not expect to owe any Maryland income tax and expect to have a right to a full refund of all income tax withheld.

If you are eligible to claim this exemption, complete Line 3 and your employer will not withhold Maryland income tax from your wages.

Students and Seasonal Employees whose annual income will be below the minimum filing requirements should claim exemption from withholding. This provides more income throughout the year and avoids the necessity of filing a Maryland income tax return.

Certification of nonresidence in the State of Maryland. Complete Line 4. This line is to be completed by residents of the District of Columbia, Pennsylvania, Virginia or West Virginia who are employed in Maryland and who do not maintain a place of abode in Maryland for 183 days or more.

Line 4 is **NOT** to be used by residents of other states who are working in Maryland, because such persons are liable for Maryland income tax and withholding from their wages is required.

If you are domiciled in the District of Columbia, Pennsylvania or Virginia and maintain a place of abode in Maryland for 183 days or more, you become a statutory resident of Maryland and you are required to file a resident return with Maryland reporting your total income. You must apply to your domicile state for any tax credit to which you may be entitled under the reciprocal provisions of the law. If you are domiciled in West Virginia, you are not required to pay Maryland income tax on wage or salary income, regardless of the length of time you may have spent in Maryland.

Under the Service members Civil Relief Act, as amended by the Military Spouses Residency Relief Act, you may be exempt from Maryland income tax on your wages if (i) your spouse is a member of the armed forces present in Maryland in compliance with military orders; (ii) you are present in Maryland solely to be with your spouse; and (iii) you maintain your domicile in another state. If you claim exemption under the SCRA enter your state of domicile (legal residence) on Line 5; enter "EXEMPT" in the box to the right on Line 5; and attach a copy of your spousal military identification card to Form MW507. **In addition, you must also complete and attach Form MW507M.**

Duties and responsibilities of employer. Retain this certificate with your records. You are required to submit a copy of this certificate and accompanying attachments to the Compliance Division, Compliance Programs Section, 301 West Preston Street, Baltimore, MD 21201, when received if:

1. you have any reason to believe this certificate is incorrect;
2. the employee claims more than 10 exemptions;
3. the employee claims an exemption from withholding because he/she had no tax liability for the preceding tax year, expects to incur no tax liability this year and the wages are expected to exceed $200 a week;
4. the employee claims an exemption from withholding on the basis of nonresidence; or
5. the employee claims an exemption from withholding under the Military Spouses Residency Relief Act.

Upon receipt of any exemption certificate (Form MW 507), the Compliance Division will make a determination and notify you if a change is required.

Once a certificate is revoked by the Comptroller, the employer must send any new certificate from the employee to the Comptroller for approval before implementing the new certificate.

If an employee claims exemption under 3 above, a new exemption certificate must be filed by February 15th of the following year.

Duties and responsibilities of employee. If, on any day during the calendar year, the number of withholding exemptions that the employee is entitled to claim is less than the number of exemptions claimed on the withholding exemption certificate in effect, the employee shall file a new withholding exemption certificate with the employer within 10 days after the change occurs.

FORM
MW507 Employee's Maryland Withholding Exemption Certificate

Print full name	Social Security number
Street Address, City, State, Zip	County of residence (or Baltimore City)

☐ Single ☐ Married (surviving spouse or unmarried Head of Household) Rate ☐ Married, but withhold at Single rate

1. Total number of exemptions you are claiming not to exceed line f in Personal Exemption Worksheet on page 2 .... 1. ______

2. Additional withholding per pay period under agreement with employer.......................... 2. $ ______

3. I claim exemption from withholding because I do not expect to owe Maryland tax. See instructions above and check boxes that apply.
   ☐ a. Last year I did not owe any Maryland Income tax and had a right to a full refund of all Income tax withheld and
   ☐ b. This year I do not expect to owe any Maryland income tax and expect to have the right to a full refund of all income tax withheld. (This includes seasonal and student employees whose annual income will be below the minimum filing requirements).
   If both a and b apply, enter year applicable ____________ (year effective) Enter "EXEMPT" here .... 3. ______

4. I claim exemption from withholding because I am domiciled in one of the following states. Check state that applies.
   ☐ District of Columbia ☐ Pennsylvania ☐ Virginia ☐ West Virginia
   I further certify that I do not maintain a place of abode in Maryland as described in the instructions above. Enter "EXEMPT" here . 4. ______

5. I certify that I am a legal resident of the state of ____________ and am not subject to Maryland withholding because I meet the requirements set forth under the Servicemembers Civil Relief Act, as amended by the Military Spouses Residency Relief Act.
   Enter "EXEMPT" here .... 5. ______

Under the **penalty of perjury,** I further certify that I am entitled to the number of withholding allowances claimed on line 1 above, or if claiming exemption from withholding, that I am entitled to claim the exempt status on line 3, 4 or 5, whichever applies.

Employee's signature	Date
Employer's Name and address including zip code (For employer use only)	Federal employer identification number

COM/RAD-036 12-49

Employee Direct Deposit Enrollment Form

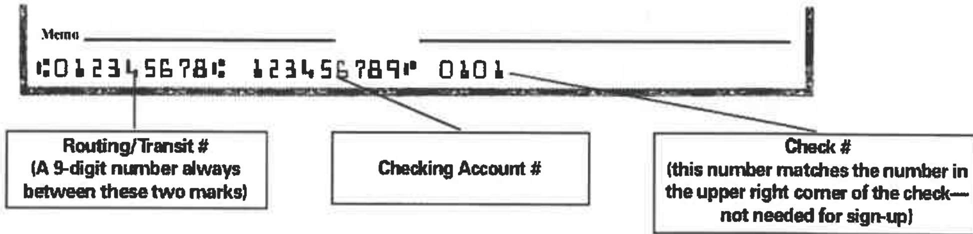
Payroll Manager—Please complete this section.

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.