SHEET METAL | AIR | RAIL | TRANSPORTATION

SMART

Discipline Income Protection Program

24950 COUNTRY CLUB BLVD., STE. 340
NORTH OLMSTED, OHIO 44070-5333
Fax: (216) 227-5209

DISCIPLINE INCOME PROTECTION PROGRAM CLAIM FORM

- Attach your Letter of Discipline or Signed Waiver showing the reason for discipline.
- Signed Waivers must clearly set forth the number of demerits, days of suspension or dismissal, and also bear the signature and title of the carrier official reflecting management acceptance.
- All discipline and dismissal events that occur or are assessed during a period for which benefits are being claimed must be reported.
- Attach the Authorization for Automatic Transfers form, available at www.smart-union.org/td/dipp

PLEASE WRITE PLAINLY – FILL OUT IN INK **ALL QUESTIONS MUST BE ANSWERED**

1. Name in full _____ Age _____
2. Address _____
3. City _____ State _____ Zip Code _____

   Telephone Number (_____) _____
4. I am a member of Local No. _____

   Soc. Sec. No. _____
5. What railroad, bus line or other transportation industry were you employed by when disciplined? _____
6. What was your occupation on date of incident? _____
7. What discipline did you receive? (Dismissal or Suspension) _____
8. Date incident occurred that caused your removal. _____
9. Date and exact time of day you last reported for duty. _____

   Ended _____
10. Date and time Investigation was conducted. _____
11. Exact time lost to attend Investigation. _____
12. IMPORTANT – Write below a report of your case, giving details of the cause of your removal from service and any other information that will assist the International in determining the validity of your claim. (Attach additional sheet if necessary.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

(over)

13. Is the cause of your removal from service as set forth by the company in their discipline notice correct? _____

14. If your answer to the above question is no, state in what respect it is not correct. _____

_____

_____

15. Number of days being claimed by this report _____ From _____ to _____ at $ _____

NOTE: Claim days up to date of report only. Benefits are not paid in advance of the discipline actually being served. Payments are based upon the date the claim report is signed.

16. If reinstated, state date and time of first day back to service. _____

I understand that it is my responsibility to notify the DIPP Department *IMMEDIATELY* upon my reinstatement to service.

I certify that, to the best of my knowledge and belief, the foregoing statements are true.

_____	_____	_____
Date	*Member's Signature*	*Local No.*

Be sure all questions are answered and that you have attached the requested documents.

After you complete this report, please present it to a Local Officer so that he/she may attest to this information.

STATEMENT OF LOCAL OFFICER

(**NOTE**: If this portion is not completed, the Claim Report will be returned.)

I am familiar with the details involved in this case of discipline and have reviewed the questions and answers given by the claimant.

Are all answers given to the questions correct to the best of your knowledge and belief? _____

Has this case been handled with the employing company? _____

What is the present status of the case? _____

_____

If needed, can an original copy of the investigation transcript be furnished? _____

_____	_____
Local Officer's Signature	*Local No.*

_____

Please Print Name

In the absence of the Local Chairperson, the signature of the Vice Local Chairperson, Local President or Local Secretary and Treasurer is acceptable providing he or she has knowledge of the matters that are being verified and providing his or her election to such office has been reported properly to the International.

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SMART Transportation Division
24950 Country Club Blvd., Ste. 340
North Olmsted, OH 44070-5333
Phone: 216-228-9400
Fax: 216-227-5209

AUTHORIZATION FOR AUTOMATIC TRANSFERS

I hereby authorize the SMART Discipline Income Protection Plan (DIPP), hereinafter called the PLAN, to deposit into my checking or savings account as directed and, if necessary, to adjust or reverse a deposit for any payment entry made to my account in error for any amount payable to me as allowed by the PLAN and as a result of my discipline claim.

Member Name:_____ **Phone:**_____ **Local:**_____
(Please Print)

Bank Information

BANK NAME:_____ **BRANCH:**_____

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

CHECKING ❑ **SAVINGS** ❑

NAME ON ACCOUNT:_____
(Please Print)

ACCOUNT NUMBER:_____

ROUTING/ABA NO.:_____

SIGNATURE:_____

DATE:_____

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

PLEASE ATTACH A VOIDED CHECK.