Bakers Union and FELRA
Health and Welfare Fund

911 Ridgebrook Road
Sparks, MD 21152-9451
Telephone: (410) 683-6500
Toll Free: (866) 662-2537
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ANNOUNCEMENT TO PARTICIPANTS

BAKERS UNION AND FELRA HEALTH AND WELFARE FUND
SUMMARY OF MATERIAL MODIFICATIONS
SEPTEMBER 2023

INCREASE IN THE WEEKLY ACCIDENT & SICKNESS BENEFIT
*****Benefit Improvement*****

This Summary of Material Modification ("SMM") contains important information about changes to the Bakers Union and FELRA Health and Welfare Fund (the "Plan"). Please read this SMM carefully, as the information described herein may impact certain rights you and your Dependents have under the Plan and may require action on your part. Please keep this document with your Summary Plan Description ("SPD") and your Summary of Benefits of Coverage ("SBC").

The Board of Trustees is very pleased to announce that effective October 1, 2023 the Weekly Accident & Sickness Benefits will be insured by Boston Mutual Life Insurance Company ("Boston Mutual"). **For eligible accidents or sicknesses occurring on or after October 1, 2023**, the current Weekly Accident & Sickness Benefit of $200 per week for a maximum of 26 weeks will increase to 50% of your weekly base earnings up to a maximum of $400 per week for 26 weeks with a minimum benefit of $200 per week.

The procedure for filing Weekly Accident & Sickness Benefits differs for Giant and Safeway Associates.

Giant Associates **- New procedure for filing Weekly Accident & Sickness Benefits for Giant Associates**:

First, contact Retail Business Services ("RBS")/ Associates Business Center ("ABS") by calling (866) 789-4748. Notify them of your absence (whether due to disability or leave of absence). They will send you a "leave of absence" packet, which contains the Boston Mutual Disability Claim Form and HIPAA Complaint Authorization Form.

You and your physician should complete your section of the claim form. RBS/ABS will complete the employer section of the form – note: this can no longer be handled at the store level! Once you and your physician have completed your sections in full, the claim form must be sent to "RBS/ABS" for completion. This can take up to five days.

Once RBS/ABS has completed the employer portion of the form, they will forward it to the Fund Office via fax. The Fund Office cannot forward the form to Boston Mutual for processing until it receives the completed Disability Claim Form with all the required information and the HIPAA Compliant Authorization Form. Determination of benefits could be delayed until all required information has been received.

Safeway Associates **- New procedure for filing Weekly Accident & Sickness Benefits for Safeway Associates:**

Contact the Fund Office at (866)662-2537 to obtain the Boston Mutual Disability Claim Form and HIPAA Compliant Authorization Form. Complete Section 1 – Employees Section of the form and have your physician complete Section 3 – Physicians Section in full. Mail the completed Disability Form and HIPAA Compliant Authorization Form to Bakers Union & FELRA Health and Welfare Fund Office, P.O. Box 1064, Sparks, MD 21152-1064. The Fund Office cannot forward the form to Boston Mutual for processing until it receives the completed Disability Claim Form with all the required information and the HIPAA Complaint Authorization Form. Determination of benefits could be delayed until all required information has been received.

Contact the Fund Office at (866)662-2537 if you have any questions.

NEW LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS CARRIER

The Board of Trustees is also very pleased to announce that beginning October 1, 2023, Boston Mutual Life Insurance Company will be the new Life Insurance and Accidental Death and Dismemberment Benefit carrier replacing Amalgamated Life Insurance Company. **Your benefits remain the same.**

BOSTON MUTUAL LIFE INSURANCE COMPANY

HOME OFFICE: 120 Royall Street • Canton, MA 02021
TEL (877) 212-2950 FAX 781-770-0492

FAMILY MATTERS. NO MATTER WHAT.

DISABILITY CLAIM KIT
FOR FILING A SHORT OR LONG TERM DISABILITY CLAIM

INSTRUCTIONS FOR FILING A DISABILITY CLAIM

Information requested in this kit is necessary to the speedy and accurate administration of your claim. If the claim form is not completed in full, determination of benefits could be delayed until all required information has been received. If a question does not apply, please write "NA" *(not applicable)* in those spaces.

There are three (3) primary sections to be completed in this kit:

Section 1: Employee Statement
Employee should fully complete this section.

Section 2: Employer's Statement
Employer should fully complete this section.

Section 3: Physician's Statement
Attending physician should fully complete this section.

A HIPAA-Compliant Authorization Form should also be fully completed by the insured and returned with this claim kit. This can be found on our website at www.bostonmutual.com.

When all sections of this form have been completed, please send it to us at the address below.

It is the responsibility of you and your employer to inform us of any scheduled or actual return to work date as soon as possible.

If an overpayment should occur on your claim, the amount of the overpayment must be returned to us.

Where to send Claim forms:

SHORT TERM DISABILITY:

Boston Mutual Life Insurance Company
120 Royall Street • Canton, MA 02021
1-877-212-2950

LONG TERM DISABILITY:

Disability RMS
300 Southborough Drive – Suite 200
South Portland, ME 04106-6914
1-877-254-0085

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BOSTON MUTUAL LIFE INSURANCE COMPANY – 1891–

FAMILY MATTERS. NO MATTER WHAT.

SECTION 1 – EMPLOYEE'S STATEMENT *(Please Print)*

Full Name *(Last, First)*	Gender ☐ M ☐ F	Date of Birth *(mo-day-yr)*	Social Security Number

Address *(City, State, Zip)*

Phone Number	Cell Phone Number	E-Mail Address

Marital Status	If married, spouse's name

List all Children *(Names and Dates of Birth)*

Date of Disability *(mo-day-yr)*	Occupation at time of disability	Is this accident or illness due to employment? YES ☐ NO ☐

Date you returned to work on a part time basis _____ *(mo-day-yr)* Date you returned to work on a full time basis _____ *(mo-day-yr)*

If you have not returned to work, when do you expect to return: Full time _____ *(mo-day-yr)* Part time _____ *(mo-day-yr)*

Describe how and where the accident occurred or describe the first symptoms of your illness:

Date first treated _____ *(mo-day-yr)* Treated by: _____ *(name and address)*

Have you ever had the same or similar condition in the past? YES ☐ NO ☐ If YES, please explain:

List all Treating Physicians/Hospitals for this accident or illness:

Name	Address	Date(s)

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FAMILY MATTERS. NO MATTER WHAT.

SECTION 1 – EMPLOYEE'S STATEMENT . . . *cont. (Please Print)*

Are you now receiving, or do you expect to receive, or have you applied for:

			Amount	Begin Date	Termination Date
YES ☐	NO ☐	Social Security			
YES ☐	NO ☐	Worker's Compensation Benefits			
YES ☐	NO ☐	Pension or Retirement Benefits			
YES ☐	NO ☐	State Sick Plan			
YES ☐	NO ☐	Auto Ins. Wage Replacement			
YES ☐	NO ☐	Salary Continuation/Sick Pay			
YES ☐	NO ☐	Any Other Benefits *(specify)*			

• IF AN INSURANCE COMPANY PROVIDES ANY OF THE ABOVE BENEFITS, PLEASE COMPLETE ITEM BELOW •

Insurer Name: _____

Address: _____ Type of Insurance: _____

If benefits are approved, do you want Federal Income Taxes withheld from your check? YES ☐ NO ☐

If yes, please state dollar amount you want withheld $ _____ per week ☐ per month ☐

If benefits are approved, do you want State Income Taxes withheld from your check? YES ☐ NO ☐

If yes, please state dollar amount you want withheld $ _____ per week ☐ per month ☐

Authorization

I CERTIFY that the information provided is true to the best of my knowledge and belief.

I HEREBY AUTHORIZE any benefit plan administrator, business associate, employer, financial institution, governmental agency, insurance and reinsurance company, insurance support organization, the Social Security Administration, Internal Revenue Service and the Veterans Administration, to furnish or release *(verbally or in writing)* or otherwise make available *(for inspection and copying)* to Boston Mutual Life Insurance Company, or its authorized representatives, all non-medical information in its possession about me. Non-medical information includes, but is not limited to: employment earnings and history, financial, insurance benefits, claims or coverage, occupational duties and traffic accident reports.

I UNDERSTAND that any information acquired pursuant to this Authorization will be used by Boston Mutual Life Insurance Company to determine my eligibility for insurance benefits under claims submitted to it, to verify representations made by me in my application for insurance or for any other lawful purpose and may be disclosed or released by Boston Mutual Life Insurance Company to: (1) re-insuring companies, (2) other persons or insurance support organizations performing business or legal services in connection with my claim or application for insurance, or (3) as may be otherwise lawfully required.

ADDITIONALLY, I have read and signed the HIPAA Authorization form to allow Boston Mutual Life Insurance Company to obtain my medical information, as allowed by the HIPAA Authorization form, and I have received and read a copy of the Boston Mutual Life Insurance Company Notice of Information Privacy Practices.

This authorization is valid for (24) twenty four months from the date of signature below.

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 subjects such person to criminal and civil penalties. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge. Please refer to the "Fraud Warning Notices" insert for your state.

X _____ _____
Signature Date

BOSTON MUTUAL LIFE INSURANCE COMPANY

HOME OFFICE: 120 Royall Street • Canton, MA 02021
TEL (877) 212-2950 FAX 781-770-0492

BOSTON MUTUAL LIFE INSURANCE COMPANY – 1891–

FAMILY MATTERS. NO MATTER WHAT.

SECTION 2 – EMPLOYER'S STATEMENT *(Please Print)*

Employee's Name *(Last, First)*	Policy No. **54849**	Division No. **1**	Insurance Class **1**

Occupation *(Please attach a copy of job description if available)*	Date of Hire	Employee's LTD/STD Effective Date	Employee's Premium Contribution % _____ ☐ Pre-Tax ☐ Post-Tax

Employee's Regular Work Schedule

_____ Days per Week _____ Hours per Day

☐ Full Time ☐ Part Time
☐ Exempt ☐ Non Exempt
☐ Seasonal

Salary Prior to Date Last Worked

Base Wages $ _____
W-2 Earnings $ _____
Overtime $ _____
Commissions $ _____
Bonus $ _____

How was Employee Paid

☐ Hourly $ _____
☐ Salaried $ _____
Date of last pay increase: _____

Date Last Worked	Hours Worked that Day	Has employee returned to work? YES ☐ NO ☐	If YES, date _____ ☐ Full TIme ☐ Part TIme

Were there any changes to the employee's job responsibilities due to the medical condition before the employee stopped working? YES ☐ NO ☐
If yes, what were the changes and when were they made?

Can the employee's job be modified to accommodate the disability either temporarily or permanently? YES ☐ NO ☐
If yes, please explain.

Is it possible to offer the employee assistance in doing the job through use of technology or personal assistance for example? YES ☐ NO ☐
If yes, please explain.

Is employee receiving or eligible to receive	YES	NO	Amount	Week	Month	Provider Name/Address *(if an insurer)*	**Date Benefits** Begin	End
Short Term Disability	☐	☐	$	☐	☐			
Salary Continuation/Sick Leave	☐	☐	$	☐	☐			
State Disability	☐	☐	$	☐	☐			
Auto Ins. Wage Replacement	☐	☐	$	☐	☐			
Social Security	☐	☐	$	☐	☐			
Worker's Compensation	☐	☐	$	☐	☐			
Has a Worker's Compensation Claim been filed?	☐	☐	If workers' compensation benefits have been denied, submit a copy of denial with the claim.					

Name and address of the employee's medical insurance carrier or HMO *(provide policy or ID No.)*

Do you have a pension plan? YES ☐ NO ☐	Is this employee eligible for your pension plan? YES ☐ NO ☐ If YES, when is employee eligible _____	What % does employee contribute? _____ %

Employer Name	Phone No.	Fax No.	
Address	City	State	Zip
Name of Person Completing this form	Title		
Signature *(The above statements are true and complete to the best of my knowledge.)*		Date	

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SECTION 3 – PHYSICIAN'S STATEMENT

Patient's Name _____

Patient is/was unable to work due to: *(check one)* ❑ Injury ❑ Illness ❑ Pregnancy EDC _____

Diagnosis *(include complications and ICD9)*	Is condition due to injury or illness arising out of patient's employment? YES ❑ NO ❑

Date you advised patient to stop working	Date of First Visit	Date of Last Visit

COMPLETE THE FOLLOWING ITEMS FOR NON-PREGNANCY RELATED CONDITIONS *(excluding Complicated Pregnancy)*

Has patient ever had same or similar condition? YES ❑ NO ❑ If YES, state when and describe

Objective Findings *(x-rays, EKG's, lab data and clinical findings)*	Subjective Symptoms
Nature of Treatment *(surgery, medications, etc.)*	Provide medication dosage and frequency

Has Patient been hospitalized? YES ❑ NO ❑

If YES, Name and Address of Hospital — Dates of Confinements

_____ _____

_____ _____

Restrictions and Limitations *(what the patient cannot do)*	Mental Impairment *(if applicable)* Provide 5 AXIS Diagnosis I IV II V III

If this is a cardiac condition, what is the functional capacity? *(American Heart Association)*

❑ Class 1 – No Limitation ❑ Class 3 – Marked Limitation

Blood Pressure *(last visit)* Systolic/Diastolic _____ / _____ ❑ Class 2 – Slight Limitation ❑ Class 4 – Complete Limitation

Has maximum medical improvement been achieved? YES ❑ NO ❑ If no, when do you expect a fundamental change? *(please specify)*

When do you estimate patient will recover sufficiently to perform the duties of his/her occupation _____ *(mo-day-yr)*

When do you estimate patient will recover sufficiently to perform the duties of any occupation _____ *(mo-day-yr)*

If employer can accommodate patient's restrictions and limitations, is patient able to return to part time and/or light duty work?

❑ YES ❑ NO *(please explain)*

Remarks:

Physician Name *(please print)*	Degree	Specialty	
Address	City	State	Zip
Phone No.	Fax No.	Tax ID No.	
Physician's Signature *(The above statements are true and complete to the best of my knowledge – No Stamps Please)*		Date	

NOTICE OF INFORMATION PRIVACY PRACTICES

Boston Mutual Life Insurance Company
(Herein referred to as "we", "us", "our")

BOSTON MUTUAL LIFE INSURANCE COMPANY – 1891–

FAMILY MATTERS. NO MATTER WHAT.

PROTECTING YOUR INFORMATION

To protect your nonpublic personal information, we maintain: physical, electronic and procedural safeguards.

COLLECTING INFORMATION

We collect information about you in order to conduct business. Such uses are: to process requests for insurance products, to provide customer service, to process claims, to fulfill legal and regulatory requirements and for other lawful purposes. We collect this information from you, as well as from other sources. We restrict access to your information to those working on our behalf who have a need to know it in order for us to provide products and services to you. We require them to secure the information and keep it confidential.

- ***Information we collect may include all the information you share with us including, for example, your:***
  - name
  - address
  - telephone number
  - date of birth
  - social security or tax identification number
  - employer name and income
  - beneficiary data
  - financial account numbers
  - medical information
  - and other information you share with us
- ***We may also collect data we receive from other sources, as allowed by law, which may include:***
  - medical information
  - consumer report information in accordance with the Fair Credit Reporting Act
  - participant information from organizations that purchase products or services from us for the benefit of their members or employees, such as group insurance
  - information to assist us in complying with state and federal laws

SHARING INFORMATION

We do not share information about our customers or former customers with anyone, except as permitted or required by law.

- ***We may share your information with third parties without your authorization as permitted by law. Such information is used on our behalf by these third parties to:***
  - process or service your insurance transactions with us
  - perform underwriting, administrative, account maintenance and claims functions
  - provide customer service or reinsurance coverage
  - prevent fraud
  - perform other business functions on our behalf
- ***We may also share your information with:***
  - a consumer reporting agency in accordance with the Fair Credit Reporting Act
  - a third party to comply with federal, state or local laws, subpoenas, or summonses
  - regulators
  - or as otherwise permitted or required by law.

Third parties receiving information from us are required to: keep it confidential and to comply with all applicable federal and state privacy laws.

ACCESS TO YOUR INFORMATION WE HAVE IN OUR RECORDS

You have the right to request access to all the information we have on you. You must make your request in writing at the address below.

AMENDMENTS TO YOUR INFORMATION

You have the right to request an amendment, correction or deletion of information which we hold about you which you believe may be inaccurate. We are not obligated to make updates to your data based on your request. You must make the request in writing and state the reasons you are requesting the change. Write us at the address below.

If you have questions about this notice or would like more information about our privacy policies, please write us at:

Boston Mutual Life Insurance Company
Attention: Privacy Office
120 Royall Street • Canton, MA 02021

420-012 3/15

FRAUD WARNING NOTICES – For Use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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: 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 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.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an 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 agent 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: 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.

DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

LOUISIANA: 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.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a 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 NH Rev. Stat. Ann. §638:20.

see other side

FRAUD WARNING NOTICES – For Use with Claim Forms *(cont.)*

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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 CIVIL FINES AND CRIMINAL PENALTIES.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance of 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, 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 may be guilty of insurance fraud.

PENNSYLVANIA: 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 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 with the penalty of 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 are 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.

RHODE ISLAND: 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.

TENNESSEE: 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.

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.

VIRGINIA: ANY PERSON WHO, WITH THE 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 MAY HAVE VIOLATED THE STATE LAW.

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.

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.

ALL OTHER STATES: 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 subjects such person to criminal and civil penalties.