Disability Claim Kit
EMPLOYEE BENEFITS

Hourly Disability Plan Claim Kit

IAM 751, 24, 70, 86, and 2766
IBEW 271
IUOE 286 and 286W

Introduction

If an illness or injury prevents you from working, this claim kit provides the materials and information you need to file a claim.

Depending on the nature of your illness or injury, benefits may begin on the first or seventh day of your disability. If you are absent from work as a result of an illness or injury, you are eligible to apply for disability benefits.

To request a leave of absence or a leave of absence kit, please call the TotalAccess Contact Center. (See “For More Information,” on page 15.)

The leave of absence kit will contain this disability claim kit. You also may print this disability claim kit from the Health & Welfare Plans section of the Employee Benefits web site *(http://www.boeing.com/benefits/)*.

Please review this claim kit and refer to your *Health and Welfare Plans* summary plan description book for details. The book is available from the Health & Welfare Plans section of the Employee Benefits web site *(http://www.boeing.com/benefits/)*.

Disability Claim Kit
EMPLOYEE BENEFITS

Table of Contents

Instructions for Filing a Claim for Benefits

To file for disability benefits, you must complete and submit both forms listed below:

- Hourly Disability Benefits Request form
- Attending Physician's Statement form

Filing for Weekly Disability Benefits

Depending on the nature of your illness or injury, benefits may begin on the first or seventh day of your disability. Please reference your *Health and Welfare Plans* summary plan description book for details *(http://www.boeing.com/benefits/)*.

Filing for Permanent and Total Disability Benefits

Aetna will send you the appropriate forms.

Step 1 **Required:** Complete and submit the Hourly Disability Benefits Request form.	
a.	Complete section 1, "Employee Information." Please type or print.
b.	Sign and date section 2, "Employee Authorization."
c.	Complete section 3, "Physician Information." Please type or print.
d.	Sign and date section 4, "Disability Income Authorization."
e.	Fax the form to Aetna at 1-877-693-7258 or mail the original to Aetna, P.O. Box 1460, Portland, OR 97207.

Step 2 **Required:** Have your physician complete the Attending Physician's Statement form.	
a.	Ask your physician to complete the entire form.
b.	Have your physician sign and date the form.
c.	Fax the form to Aetna at 1-877-693-7258 or mail the original to Aetna, P.O. Box 1460, Portland, OR 97207.

Remember: Aetna must receive both the Hourly Disability Benefits Request form and Attending Physician's Statement form before your claim for benefits will be considered.

Step 3 **Optional:** Tax Deductions
Please call Aetna for information about taxation of disability benefits. (See "For More Information," on page 15.) You also should check with your tax adviser for additional information.

Remember: When your disability ends, please call Aetna and TotalAccess. (See "For More Information," on page 15.)

BOEING®

Hourly Disability Benefits Request Form

Instructions: Complete sections 1 and 3; sign and date sections 2 and 4.

1. EMPLOYEE INFORMATION

NAME First Middle Last		SOCIAL SECURITY NUMBER	SHIFT ☐ 1st ☐ Other
HOME ADDRESS		DATE OF BIRTH / /	STATUS ☐ Full time ☐ Part time
		GENDER ☐ Male ☐ Female	JOB TITLE/OCCUPATION
HOME PHONE	WORK PHONE	MANAGER'S NAME: PHONE:	
LAST DAY WORKED	RETURN TO WORK DATE (if known)	WAS MORE THAN 1/2 SHIFT WORKED ON THE LAST DAY? ☐ Yes ☐ No	

LIST ANY OTHER INCOME BENEFITS YOU HAVE APPLIED FOR OR ARE RECEIVING (SUCH AS WORKERS' COMPENSATION, SOCIAL SECURITY, OTHER RETIREMENT INCOME, OR MILITARY PAY)

BENEFIT _____

AMOUNT $ _____ Per ☐ Day ☐ Week ☐ Month

WAS CONDITION RELATED TO

EMPLOYMENT? ☐ Yes ☐ No

ACCIDENT? ☐ Yes ☐ No

CAUSE OF DISABILITY

IF AN ACCIDENT:

DATE OF ACCIDENT: / /

PLACE IT HAPPENED:

HOW IT HAPPENED:

2. EMPLOYEE AUTHORIZATION

To all providers of health care:

You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), and any independent claim administrators and consulting health professionals and utilization review organizations with whom Aetna has contracted, information concerning health care advice, treatment or supplies provided the patient (including that related to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits. Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. In the event of an employee's long term disability, Aetna may provide employee's life insurance carrier with the minimum diagnostic information necessary to implement the premium disability waiver provision of such life insurance coverage. This authorization is valid for the term of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of the authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Employee's or Authorized Person's Signature: _____ **Date:** / /

3. PHYSICIAN INFORMATION

List the physicians now attending you.

Physician's Name	Physician's Address and Phone	Condition
	☐	
	☐	
	☐	

4. DISABILITY INCOME AUTHORIZATION

I request disability plan benefits. If I receive any payment(s) as a result of this disability (other than Boeing benefits), I will report it (them) to Aetna (please refer to your benefit booklet for a complete list of payments that are considered other income benefits). I authorize The Boeing Company or Aetna, as the administrative agent for Boeing, to recover overpayments by deducting them from future disability benefits, paychecks, or through other methods. I authorize the exchange of information between The Boeing Company and Aetna and/or their agents for the purposes of administering these benefits. I understand that prior to the payment of any benefit under this plan, I must authorize release of such medical records as Aetna in its sole discretion determines are necessary.

Employee's or Authorized Person's Signature: _____ **Date:** / /

Send the completed, signed form and Attending Physician's Statement form to:
Aetna, P.O. Box 1460, Portland, OR 97207, Fax: 1-877-693-7258, Phone: 1-800-882-5968

Disability
Attending Physician's Statement

- The patient is responsible for completion of this form without expense to the company.
- You may use the Remarks section on the reverse side if you need more room to respond.
- Complete this form in full and send to:

Aetna
P.O. Box 1460
Portland, OR 97207

- Please fax your completed form to our Portland, Oregon office at **(877) 693-7258**.
  (**NOTE:** The top portion of Page 2 **MUST** be completed before faxing.)
- If you have any questions, please call our Portland, Oregon office at **(800) 882-5968**.

Employer Information

Name: ***BOEING***

Type of Claim: ☐ Disability ☐ Life Waiver of Premium ☐ PTD

Patient Information

Name | Social Security Number | Birthdate (MM/DD/YYYY)

Address (include No. Street, Town, State, Zip Code) ☐ Address is new

1. History

(a) Height _____ Weight _____
(b) Date symptoms first appeared or accident happened ..... Mo. _____ Day _____ Yr. _____
(c) Date patient ceased work because of illness or injury ..... Mo. _____ Day _____ Yr. _____
(d) Has patient ever had same or similar condition? ☐ No ☐ Yes, state when and describe.
(e) Is condition due to injury or sickness arising out of patient's employment? ☐ No ☐ Yes ☐ Unknown
(f) Names and addresses of other treating physicians
Name _____ Address _____
Name _____ Address _____
Name _____ Address _____
(g) For medical reasons, the above named person will need to be absent from work due to a disability beginning on _____ And ending on _____ .

2. Diagnosis

(a) Date of last examination ..... Mo. _____ Day _____ Yr. _____
(b) ICD diagnostic code (**mandatory**)
(c) Diagnosis (including any complications) _____
(d) Subjective symptoms

(e) Objective findings (including **current** X-rays, EKG's, laboratory data and any **clinical findings**):
(1.) **Clinical Findings**:

(2.) **Diagnostic Studies and Results**:

(f) If disability is due to pregnancy, the expected delivery date is ..... Mo. _____ Day _____ Yr. _____
(g) Other disease or infirmity affecting present condition _____

3. Dates of Treatment

(a) Date of first visit ..... Mo. _____ Day _____ Yr. _____
(b) Date of last visit ..... Mo. _____ Day _____ Yr. _____
(c) Frequency ..... ☐ Weekly ☐ Monthly ☐ Other (specify) _____
(d) Is patient still under your care for this condition?
☐ Yes ☐ No, indicate date service terminated. _____

4. Nature of Treatment

(a) Type and dates of treatment:
(b) Prescribed medications:
(c) Surgical procedures and dates:

5. Progress

(a) Patient has ..... ☐ Recovered ☐ Improved ☐ Stabilized ☐ Retrogressed
(b) Patient is ..... ☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined
(c) Has patient been hospital confined?
☐ No ☐ Yes, give name and address of hospital _____
_____
Confined from _____ through _____

Employer Information (REQUIRED)	Patient Information (REQUIRED)	Social Security Number (REQUIRED)
BOEING		

6. Cardiac (if applicable)

(a) Functional capacity limitation (American Heart Ass'n): ☐ Class 1 (none) ☐ Class 2 (slight) ☐ Class 3 (marked) ☐ Class 4 (complete)

(b) Blood Pressure (last visit): _____ / _____ Systolic / Diastolic

7. Limitations

(a) What are patient's present capabilities?

(b) What are present limitations (physical and/or mental)?

(c) What restrictions are placed on patient?

8. Physical Impairment

- As defined in Federal Dictionary of Occupational Titles.

☐ Class 1 - No limitation of functional capacity; capable of heavy work*. No restrictions. (0-10%)
☐ Class 2 - Medium manual activity.* (15-30%)
☐ Class 3 - Slight limitation of functional capacity; capable of light work.* (35-55%)
☐ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60-70%)
☐ Class 5 - Severe limitation of functional capacity; incapable of minimal (sedentary*) activity. (75-100%)
☐ Remarks: _____

9. Mental/ Nervous Impairment (if applicable)

Please define "stress" as it applies to this claimant.

Do you believe the patient is competent to endorse checks and direct the use of proceeds thereof? ☐ No ☐ Yes

10. Prognosis

(a) What is the patient's prognosis?
☐ Guarded ☐ Good ☐ Fair ☐ Poor ☐ Other

(b) When do you feel patient's maximum medical improvement will be reached?
☐ 1 Mo. ☐ 1-3 Mos. ☐ 3-6 Mos. ☐ 6-9 Mos. ☐ 1 yr. or longer

(c) What is the estimated date of the patient's return to work?
☐ own job/occ _____ ☐ other occ _____ ☐ no return expected

(d) Do you consider the patient to be a viable candidate for **Vocational Rehabilitation** (job retraining)?
☐ Yes ☐ No, please explain _____

Remarks

Attending Physician's Name (print)	Specialty	Degree

Address (No. Street, City, State, Zip Code)	Telephone

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 claim was provided by the applicant.

California Residents: For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties. **Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.**

Pennsylvania Residents: 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.

Signature	Date

Form W-4 (2003)

Purpose. Complete Form W-4 so that your employer can withhold the correct Federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2003 expires February 16, 2004. See **Pub. 505,** Tax Withholding and Estimated Tax.

Note: *You cannot claim exemption from withholding if:* ***(a)*** *your income exceeds $750 and includes more than $250 of unearned income (e.g., interest and dividends) and* ***(b)*** *another person can claim you as a dependent on their tax return.*

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earner/two-job situations. Complete all worksheets that apply. **However, you may claim fewer (or zero) allowances.**

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See line **E** below.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See **Pub. 919,** How Do I Adjust My Tax Withholding? for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using **Form 1040-ES,** Estimated Tax for Individuals. Otherwise, you may owe additional tax.

Two earners/two jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others.

Nonresident alien. If you are a nonresident alien, see the **Instructions for Form 8233** before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2003. See Pub. 919, especially if your earnings exceed $125,000 (Single) or $175,000 (Married).

Recent name change? If your name on line 1 differs from that shown on your social security card, call 1-800-772-1213 for a new social security card.

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . **A** _____

B Enter "1" if:
- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,000 or less.

. . **B** _____

C Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . . **C** _____

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . . **D** _____

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . **E** _____

F Enter "1" if you have at least $1,500 of **child or dependent care expenses** for which you plan to claim a credit . . **F** _____
(**Note:** *Do* ***not*** *include child support payments. See* ***Pub. 503,*** *Child and Dependent Care Expenses, for details.*)

G **Child Tax Credit** (including additional child tax credit):
- If your total income will be between $15,000 and $42,000 ($20,000 and $65,000 if married), enter "1" for each eligible child plus **1 additional** if you have three to five eligible children or **2 additional** if you have six or more eligible children.
- If your total income will be between $42,000 and $80,000 ($65,000 and $115,000 if married), enter "1" if you have one or two eligible children, "2" if you have three eligible children, "3" if you have four eligible children, or "4" if you have five or more eligible children. **G** _____

H Add lines A through G and enter total here. **Note:** *This may be different from the number of exemptions you claim on your tax return.* ► **H** _____

For accuracy, complete all worksheets that apply.
- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $35,000, see the **Two-Earner/Two-Job Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Cut here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **For Privacy Act and Paperwork Reduction Act Notice, see page 2.**

OMB No. 1545-0010

2003

1 Type or print your first name and middle initial	Last name	**2** Your social security number
Home address (number and street or rural route)		**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** *If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.*
City or town, state, and ZIP code		**4** **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a new card.** ► ☐

5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) **5**

6 Additional amount, if any, you want withheld from each paycheck . . . . . **6** $

7 I claim exemption from withholding for 2003, and I certify that I meet **both** of the following conditions for exemption:
- Last year I had a right to a refund of **all** Federal income tax withheld because I had **no** tax liability **and**
- This year I expect a refund of **all** Federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . . . ► **7**

Under penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate, or I am entitled to claim exempt status.

Employee's signature
(Form is not valid unless you sign it.) ► **Date** ►

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number

Deductions and Adjustments Worksheet

Note: *Use this worksheet **only** if you plan to itemize deductions, claim certain credits, or claim adjustments to income on your 2003 tax return.*

1	Enter an estimate of your 2003 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2003, you may have to reduce your itemized deductions if your income is over $139,500 ($69,750 if married filing separately). See **Worksheet 3** in Pub. 919 for details.)	**1**	$
2	Enter: $7,950 if married filing jointly or qualifying widow(er); $7,000 if head of household; $4,750 if single; $3,975 if married filing separately	**2**	$
3	**Subtract** line 2 from line 1. If line 2 is greater than line 1, enter "-0-"	**3**	$
4	Enter an estimate of your 2003 adjustments to income, including alimony, deductible IRA contributions, and student loan interest	**4**	$
5	**Add** lines 3 and 4 and enter the total. Include any amount for credits from **Worksheet 7** in Pub. 919	**5**	$
6	Enter an estimate of your 2003 nonwage income (such as dividends or interest)	**6**	$
7	**Subtract** line 6 from line 5. Enter the result, but not less than "-0-"	**7**	$
8	**Divide** the amount on line 7 by $3,000 and enter the result here. Drop any fraction	**8**	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	**9**	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earner/Two-Job Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	**10**	

Two-Earner/Two-Job Worksheet

Note: *Use this worksheet **only** if the instructions under line H on page 1 direct you here.*

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	**1**	
2	Find the number in **Table 1** below that applies to the **lowest** paying job and enter it here	**2**	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	**3**	

Note: *If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4–9 below to calculate the additional withholding amount necessary to avoid a year-end tax bill.*

4	Enter the number from line 2 of this worksheet	**4**	
5	Enter the number from line 1 of this worksheet	**5**	
6	**Subtract** line 5 from line 4	**6**	
7	Find the amount in **Table 2** below that applies to the **highest** paying job and enter it here	**7**	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	**8**	$
9	Divide line 8 by the number of pay periods remaining in 2003. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2002. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	**9**	$

Table 1: Two-Earner/Two-Job Worksheet

Married Filing Jointly

If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $4,000	0	44,001 - 50,000	8
4,001 - 9,000	1	50,001 - 60,000	9
9,001 - 15,000	2	60,001 - 70,000	10
15,001 - 20,000	3	70,001 - 90,000	11
20,001 - 25,000	4	90,001 - 100,000	12
25,001 - 33,000	5	100,001 - 115,000	13
33,001 - 38,000	6	115,001 - 125,000	14
38,001 - 44,000	7	125,001 and over	15

All Others

If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	75,001 - 100,000	8
6,001 - 11,000	1	100,001 - 110,000	9
11,001 - 18,000	2	110,001 and over	10
18,001 - 25,000	3		
25,001 - 29,000	4		
29,001 - 40,000	5		
40,001 - 55,000	6		
55,001 - 75,000	7		

Table 2: Two-Earner/Two-Job Worksheet

Married Filing Jointly

If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $50,000	$450
50,001 - 100,000	800
100,001 - 150,000	900
150,001 - 270,000	1,050
270,001 and over	1,200

All Others

If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $30,000	$450
30,001 - 70,000	800
70,001 - 140,000	900
140,001 - 300,000	1,050
300,001 and over	1,200

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. The Internal Revenue Code requires this information under sections 3402(f)(2)(A) and 6109 and their regulations. **Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may also subject you to penalties.** Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, and the District of Columbia for use in administering their tax laws, and using it in the National Directory of New Hires. We may also disclose this information to Federal and state agencies to enforce Federal nontax criminal laws and to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The time needed to complete this form will vary depending on individual circumstances. The estimated average time is: **Recordkeeping,** 46 min.; **Learning about the law or the form,** 13 min.; **Preparing the form,** 59 min. If you have comments concerning the accuracy of these time estimates or suggestions for making this form simpler, we would be happy to hear from you. You can write to the Tax Forms Committee, Western Area Distribution Center, Rancho Cordova, CA 95743-0001. **Do not** send the tax form to this address. Instead, give it to your employer.

Questions and Answers
Weekly Disability Benefits

Benefits, Claims and Payments

1. Who may apply for Weekly Disability Plan benefits?

Employees represented by the following unions are eligible for benefits under the Weekly Disability Plan:

- International Association of Machinists and Aerospace Workers, AFL-CIO, Aerospace Industrial District Lodge No. 751, District Lodge No. 24, District Lodge No. 70, Local No. 86, and Space City Lodge No. 2766
- International Brotherhood of Electrical Workers, AFL-CIO, Local No. 271
- International Union of Operating Engineers Local No. 286 and Local No. 286W

Depending on the nature of your illness or injury, you may qualify for benefits beginning on the first or seventh day of your disability.

2. What is the definition of *disabled* in relation to Weekly Disability Plan benefits?

Disabled means that you are unable to work your regular occupation as a result of illness (including a pregnancy-related condition) or accidental injury (on or off the job).

3. What is the weekly benefit amount that will be payable to me?

The weekly benefit amount varies depending on whether or not your illness or accidental injury is related to a workers' compensation illness or injury, in addition to your labor grade, job code, or other classification at the time your disability first begins. Please consult your collective bargaining agreement, *Health and Welfare Plans* summary plan description book, Aetna, or the Boeing Service Center for Health and Welfare Plans for specific benefit information. (See "For More Information," on page 15.)

4. When should I file a claim for Weekly Disability Plan benefits?

You should file a Weekly Disability Plan claim as soon as you have satisfied the waiting period and a physician states that you are unable to work. Please consult your *Health and Welfare Plans* summary plan description book for specific information about waiting periods *(http://www.boeing.com/benefits/)*.

Depending on the nature of your illness or injury, plan benefits may not be available immediately. Plan benefits are not available until Aetna approves your claim. The claim process may take up to three weeks after your date of disability.

You may submit a claim before your absence occurs if the absence is scheduled (e.g., for surgery or because of pregnancy).

You must submit your claim for weekly disability benefits within 90 days of the date your disability benefits are first payable.

5. How may I get a disability plan claim kit?

You may print the disability claim kit from the Health & Welfare Plans section of the Employee Benefits web site *(http://www.boeing.com/benefits/).* The disability claim kit also is included in the leave of absence kit, which you can request by calling TotalAccess. (See "For More Information," on page 15.)

6. How may I get an Hourly Disability Benefits Request form?

You may print the Hourly Disability Benefits Request form from the Health & Welfare Plans section of the Employee Benefits web site *(http://www.boeing.com/benefits/)*. The claim form also is included in the leave of absence kit, which you can request by calling TotalAccess. (See "For More Information," on page 15.) Claim forms also are available from your union office.

7. If my benefits do not begin until the seventh day, what funds may I receive during the first six days of absence?

During your first six days of absence, you may receive income by using sick leave pay or vacation pay.

8. How much will I pay for health and welfare coverages while I am receiving Weekly Disability Plan benefits?

Your regular contributions will continue for health and welfare coverages, if applicable, except for the dependent care reimbursement account, during the first six months of medical leave. Dependent care reimbursement account contributions will end on the date your leave begins. Your contributions will be taken from any payments made by the payroll department (i.e., sick leave pay, vacation pay) as long as there is sufficient pay to take a deduction. After that, the Boeing Service Center for Health and Welfare Plans will bill you for coverage.

9. If my labor grade, job code, or other classification changes, when will my Weekly Disability Plan payments change?

If you are actively at work and your labor grade, job code, or other classification changes, the coverage amount (the weekly benefit for which you may be eligible) will automatically change on the first day of the month following or coinciding with the date the Boeing Service Center for Health and Welfare Plans is notified of the change in your status.

However, if you are not actively at work on the day the coverage change is to become effective, the effective date for your new coverage amount will be delayed until the first day of the month following or coinciding with the day you return to work for one full day.

Please consult your *Health and Welfare Plans* summary plan description book for details *(http://www.boeing.com/benefits/)*.

Deductions From Disability Payments

10. What tax deductions will be taken from my Weekly Disability Plan benefits?

Please call Aetna for details. (See "For More Information," on page 15.)

Return to Work

11. What will I have to do when I return to work on my regular schedule?

You should call TotalAccess when you are ready to return from a leave of absence. You also need to call Aetna to avoid any overpayment of disability benefits. (See "For More Information," on page 15.)

12. What will happen if I return to work for a brief time and then go back on leave?

If you return to work for fewer than 30 days and go back on leave of absence because of the same illness or injury, your second period of disability will be treated as an extension of your first period of disability. No waiting period will apply, and you will be eligible for disability benefits for up to 26 weeks, including the first period of disability, subject to Aetna's approval.

If you return to work for at least 30 consecutive days and go back on leave of absence, you will begin a new period of benefits. A waiting period will apply.

If you return to work for at least one full day and go back on leave of absence for a different illness or injury, the second period of disability will be considered a new, separate 26-week period of disability. A new waiting period will apply.

Please call Aetna and TotalAccess in any of the above circumstances. (See "For More Information," on page 15.)

13. What will happen if I return to work on a reduced schedule?

If your disability prevents you from working your regular schedule and you plan to return to work on a reduced schedule, please call Aetna. (See "For More Information," on page 15.)

Permanent and Total Disability Benefits

Benefits, Claims, and Payments

1. Who may apply for Permanent and Total Disability Plan benefits?

Employees represented by the following unions may be eligible for permanent and total disability benefits:

- International Association of Machinists and Aerospace Workers, AFL-CIO, Aerospace Industrial District Lodge No. 751, District Lodge No. 24, District Lodge No. 70, Local No. 86, and Space City Lodge No. 2766
- International Brotherhood of Electrical Workers, AFL-CIO, Local No. 271
- International Union of Operating Engineers Local No. 286 and Local No. 286W.

If you become permanently and totally disabled before age 60, you may qualify for permanent and total disability benefits.

2. What is the definition of *disabled* in relation to permanent and total disability benefits?

You may be considered permanently and totally disabled if one of the following applies to you:

- Your disability has existed continuously for six months and presumably will prevent you from engaging in any employment for pay or profit for the rest of your life, including employment for which you may become fitted by education, training, or experience.
- You have experienced the entire and irrecoverable loss of sight in both eyes.
- You have lost the use of both hands or both feet or of one hand and one foot.

3. What is the monthly benefit amount that will be payable to me?

Permanent and total disability benefits are monthly installments of your life insurance benefit. The monthly benefit payable to you would be $500. *Each monthly benefit you receive is a deduction from your life insurance benefit.*

Your full life insurance benefit is the amount of life insurance in effect on the date your total disability begins. Interest does accrue on the unpaid balance as disbursements are made to you.

4. When should I file a claim for Permanent and Total Disability Plan benefits?

Aetna will send you the appropriate forms if your condition during your weekly disability claim reflects a permanent and total disability. You do not need to complete another Hourly Disability Benefits Request Form.

You must submit your proof of disability within 12 months of the time you are no longer actively at work because of the disabling condition.

5. How much will I pay for health and welfare coverages while I am receiving Permanent and Total Disability Plan benefits?

- You will be eligible to continue your current medical coverage through COBRA by paying the active employee contribution rate. You will be eligible to continue your current dental coverage through COBRA by paying the full cost of the premium. The Boeing Service Center for Health and Welfare Plans will forward information to you and your dependents, if applicable, regarding COBRA rights.
- If your approved medical leave extends beyond six months and you still are totally disabled, your coverage under the Life Insurance Plan, Survivor Income Plan, and Accidental Death and Dismemberment Plan can be continued for up to 24 months if you pay the full cost of the premiums.
- If you become permanently and totally disabled before age 60, you may be able to continue your coverage under the Life Insurance Plan at no cost to you. Please consult your *Health and Welfare Plans* summary plan description book for specific details *(http://www.boeing.com/benefits/)*.

Deductions From Disability Payments

6. What tax deductions will be taken from my Permanent and Total Disability Plan benefits?

Please call Aetna for details. (See "For More Information," on page 15.)

Return to Work

7. What will I have to do when I return to work on my regular schedule?

You should call TotalAccess when you are ready to return from a leave of absence. You also need to call Aetna to avoid any overpayment of disability benefits. (See "For More Information," on page 15.)

8. What will happen if I return to work for a brief time and then go back on leave?

If you return to work for fewer than 30 days and go back on leave of absence because of the same or related illness or injury, your second period of disability will be treated as an extension of your first period of disability.

If you recover and return to work, the amount of the unpaid life insurance benefit plus accrued interest will be reinstated as your total life insurance benefit. This reduced amount of life insurance is the maximum benefit payable in case of your death or in the case of subsequent disabilities.

9. What will happen if I return to work on a reduced schedule?

If your disability prevents you from working your regular schedule and you plan to return to work on a reduced schedule, please call Aetna and TotalAccess. (See "For More Information," on page 15.)

For More Information

For information about . . .	Please call . . .	At . . .
Eligibility for weekly and permanent and total disability benefits	Boeing Service Center for Health and Welfare Plans, through the TotalAccess Contact Center	1-866-473-2016 (hearing impaired: use your relay service; from outside the U.S.A., through Boeing operator: 206-655-2121) 1. At the first prompt, ask the system for benefits. 2. At the second prompt, ask the system for health and welfare. You will need your health and welfare password and Social Security number. Representatives are available Monday through Friday from 9 a.m. to 8 p.m. ET (8 a.m. to 7 p.m. CT; 7 a.m. to 6 p.m. MT; 6 a.m. to 5 p.m. PT).
Filing a claim for disability benefits	Aetna	1-800-882-5968 (hearing impaired: 503-937-0460) Representatives are available Monday through Friday from 10 a.m. to 8 p.m. ET (9 a.m. to 7 p.m. CT; 8 a.m. to 6 p.m. MT; 7 a.m. to 5 p.m. PT).
• Requesting a leave of absence or a leave of absence kit • Sick leave or vacation payments	TotalAccess Contact Center	1-866-473-2016 (hearing impaired: use your relay service; from outside the U.S.A., through Boeing operator: 206-655-2121) At the prompt, ask the system for "another service." You will need your BEMS ID number and TotalAccess personal identification number.