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FRISCO LINES

Insurance Manual

for

Employees

of

St. Louis-San Francisco Railway Company

FRISCO LINES

Revised August, 1926

Foreword

THIS booklet is intended as an explanation of contract rights between the METROPOLITAN LIFE INSURANCE COMPANY and the ST. LOUIS-SAN FRANCISCO RAILWAY COMPANY. It is not issued for the purpose of changing any of those rights, everything in this booklet being subject to the wording of the contract between the two companies.

Outline of the Group Insurance Plan

To all Shop Craft, Supervisory, and Clerical Employees of the St. Louis-San Francisco Railway Company:

The St. Louis-San Francisco Railway Company has arranged a Plan of Insurance Protection with the Metropolitan Life Insurance Company of New York. This offer is extended to all Shop Craft, Supervisory and Clerical employees, who have been continuously employed for three months and who are actively at work.

Shop Craft Employees are Offered:

1. $1,000 *Life Insurance with Total and Permanent Disability Provision.*
2. 1,000 *Accidental Death and Dismemberment Insurance.*
3. 10 *Weekly Benefit Health and Accident Insurance.*

The total cost of this Insurance to each Shop Craft employee who participates is $1.50 per month.

Supervisory Employees Are Offered:

1. Life Insurance with Total and Permanent Disability Provision, based on the following schedule:

Class A—Employees earning $200 or less per month..$5,000
Class B—Employees earning $201 but less than $300 per month..... 7,000
Class C—Employees earning $300 and over per month. 9,000

2. Accidental Death and Dismemberment Insurance based on the following schedule:

Class A—Employees earning $200 or less per month...$3,000
Class B—Employees earning $201 but less than $300 per month..... 4,000
Class C—Employees earning $300 and over per month. 5,000

The total cost per month, of this Insurance to each Supervisory employee who participates is as follows:

	Life	Death and Dismemberment	Total Monthly Cost
Class A	4.42	.39	4.81
Class B	6.14	.52	6.66
Class C	7.88	.65	8.53

Salary Increases and Decreases

If an employee's salary decreases, his amount of Insurance is to remain the same. If his salary increases the amount of Insurance must be increased to the class corresponding with his salary. Increase to be effective the August 1st following such change.

Employees in the Clerical Forces Are Offered:

Life Insurance with Total and Permanent Disability Provision based on the following schedule:

Class A—Employees earning $4 per day or less.....$1,000
Class B—Employees earning more than $4 per day... 2,000

The total cost to each employee in the Clerical Forces who participates is as follows:

Class A.....$ .55 per month
Class B..... 1.10 per month

Salary Increases and Decreases

If an employee's salary decreases, his amount of Insurance is to remain the same. If his salary increases the amount of Insurance must be increased to the class corresponding with his salary. Increase to be effective the October 1st, following such change.

Payment of Premiums

Each employee's share of the premium will be deducted from his pay once each month. The balance of the net cost of this Insurance is to be paid by the St. Louis-San Francisco Railway Company, and subsidiary companies.

1—*Life Insurance with Total and Permanent Disability Benefits*

(*a*) Life Insurance, the entire amount is payable in case of death from any cause, to the beneficiary named by the employee.

(*b*) This Life Insurance is also payable in instalments to the insured employee should he become totally and permanently disabled before

he reaches the age of sixty. Any employee shall be considered as totally and permanently disabled who furnishes proof that he is permanently, continuously and wholly prevented from performing work for compensation or profit because of bodily injury suffered or disease acquired while his insurance is in force, before he has reached his sixtieth birthday.

Upon receipt of proof of such disability, the METROPOLITAN LIFE INSURANCE COMPANY will pay to the employee instead of the payment at death, monthly instalments as follows, determined by the amount of insurance in force:

AMOUNT OF INSURANCE	NUMBER OF INSTALMENTS	AMOUNT OF EACH INSTALMENT
$1,000	20	$51.04
2,000	40	52.50
5,000	60	90.00
7,000	60	126.00
9,000	60	162.00

These instalment payments will be made only during the continuance of such disability. The payments in no way conflict with any other compensation. They are payable for disability occuring either *on* or *off* the job, whether the result of sickness or accident.

In the event of the death of such an employee during the period of total and permanent disability, the present value of any instalments remaining unpaid will be paid, in one sum, to his beneficiary.

2—*Accidental Death and Dismemberment Insurance*

Accidental Death and Dismemberment Insurance is payable for all accidental deaths and dismemberments caused by accidents *on* or *off* the job. It does not conflict with compensation claims. The entire amount is payable to the beneficiary, together with the Life Insurance, in case of accidental death. It also provides benefits for the insured employee himself. When the accident does not result in death, but causes any of the following losses payments will be made as indicated:

For Permanent Loss of Sight of Both Eyes..Entire Amount
For Loss of Both Hands.....Entire Amount
For Loss of Both Feet.....Entire Amount
For Loss of One Hand and Permanent Loss of Sight.....Entire Amount
For Loss of Hand and Foot.....Entire Amount
For Loss of One Foot.....One half Entire Amount
For Loss of One Hand.....One-half Entire Amount
For Permanent Loss of Sight of One Eye.....One-half Entire Amount

If an employee covered by Accidental Death and Dismemberment Insurance loses one hand or one foot or the sight of one eye permanently, he will be paid one-half the entire amount. His protection remains the same except that in the event of the loss of the other corresponding member, he will be paid an additional sum equal to one-half the entire amount.

EXAMPLE (1) An employee insured for $1,000 loses his right leg and collects $500. Should he lose his left leg at a later date he will be paid an additional $500.

EXAMPLE (2) An employee insured for $1,000 loses his right leg and collects $500. Should he lose both his arms at a later date or meet with accidental death he, or his beneficiary will collect $1,000.

3—*Health and Accident Insurance (Shop Craft Employees Only)*

Health and Accident Insurance provides for protection in case of any sickness or accident occuring while on or off the job. The only requirement is that the employee must be treated by a licensed practicing physician during his incapacity. This insurance provides for the payment of $10 a week for a period not exceeding thirteen consecutive weeks for any one absence. In no case, however, are benefits payable for the first seven days of incapacity.

New Eligible Employees

This offer is open to all new employees after they complete three months of continuous service with the company. It is required, however, that they make written application within thirty-one days following the completion of three months' service. They must be actively at work on date they apply. Employees absent may make application immediately upon their return to

active duty. The insurance is effective from the first day of the calendar month, following the date on which the application is signed.

Applications for Insurance must be made by each employee within thirty-one (31) days following the completion of three months' continuous employment. Should any employee desire this Insurance after the thirty-one (31) days have expired, he will be required to submit to and successfully pass a physical examination as required by the METROPOLITAN LIFE INSURANCE COMPANY at his expense, before his application will be accepted. In these cases, the Insurance is effective the first day of the calendar month following the date of the acceptance of the physical examination by the METROPOLITAN LIFE INSURANCE COMPANY.

Certificates

Each insured employee will receive a certificate which will show the amount of insurance in force under each class of insurance. They will be issued in the name of the individual employee by the METROPOLITAN LIFE INSURANCE COMPANY. The certificates will be forwarded to you through the Department in which you are employed as soon as possible after making your application.

Termination of Insurance

All Insurance is discontinued when employment with the ST. LOUIS-SAN FRANCISCO RAILWAY

COMPANY ceases, except in cases of retirement on pension because of age or physical infirmity. Health and Accident Insurance in such cases will be canceled effective on date of such retirement, and thereafter payroll deduction will be 62 cents in lieu of the regular $1.50 monthly rate. Any employee requesting the discontinuance of his insurance while in the employ of the ST. LOUIS-SAN FRANCISCO RAILWAY COMPANY will have his insurance cancelled at the end of the calendar month for which his last payment was made.

Privilege of Continuance

Employees leaving the employment of the Railway Company may change their Group Insurance to a regular contract as issued by the METROPOLITAN LIFE INSURANCE COMPANY and in accordance with the Privilege of Continuance Clause appearing on the face of their certificates, without medical examination. It should be remembered that written application for the continuance of this Insurance must be made to the Insurance Company within thirty-one (31) days after termination of employment.

Presentation and Payment of Claims

1. DEATH CLAIMS.—Upon the death of any insured employee, METROPOLITAN LIFE INSURANCE COMPANY Form O34 should be prepared, and together with the Life Insurance Certificates, sent to the Department in which he was employed. The Department head will then approve

and forward to the Superintendent of Insurance of the ST. LOUIS-SAN FRANCISCO RAILWAY COMPANY, St. Louis, Mo., and payment will immediately be made to the designated beneficiary. If the beneficiary is a minor, a Court Order must be secured showing the appointment of a Guardian. If the beneficiary dies before the insured, the insurance will be paid to the Estate of the insured. A court certificate showing the appointment of an Administrator or Executor should be secured and sent with the Proof of Death Form O34 and Life Insurance Certificates. If the insurance is payable to the Estate, it will also be necessary to secure a court certificate showing the appointment of an Administrator or Executor which should be sent as outlined above. If death is due to an accident, Form O34 should be plainly marked, "Death Due to Accident."

2. TOTAL AND PERMANENT DISABILITY CLAIMS.—If an insured employee under 60 years of age becomes totally and permanently disabled through any cause whatsoever, the facts should be submitted to the Superintendent of Insurance of the ST. LOUIS-SAN FRANCISCO RAILWAY COMPANY, St. Louis, Mo. Upon receipt of proof of such claim the Insurance will be paid in instalments to the disabled employee as previously outlined. Medical evidence of continued disability may be required from time to time by the Insurance Company. Such requests should be given immediate attention.

3. Sickness and Accident Claims.—(Shop Craft Employees Only). If the insured employee becomes sick or injured and is thereby entitled to benefits under his Group Health and Accident Insurance Certificate, after 7 days absence, the Metropolitan Life Insurance Company's Form G.H. 24C, claim proof should be prepared promptly by the employee and attending physician.

From time to time the Metropolitan Life Insurance Company may require further evidence of continued disability. In such cases the Insurance Company will forward Form G.H. 117 (Supplementary Medical Report) for completion by the claimant's doctor. This form should be promptly completed and sent through the usual channels.

All claim forms should be turned over to the employee's foreman or Department Head for his attention and further handling. The claim form should be properly approved by his Department Head and forwarded through the regular channels to the Superintendent of Insurance of the St. Louis-San Francisco Railway Company, St. Louis, Mo. and payments will then be made weekly as they become due.

4. Dismemberment Claims.—If an insured employee suffers any of the losses listed under Accidental Death and Dismemberment Insurance, the procedure will be the same as that outlined under the paragraph immediately preceding,

except the Form G.H.24C must be prominently marked, "Dismemberment Due to Accident," and in addition question nine (9) on this form must be carefully answered in detail. The claim form should be accompanied by the Accidental Death and Dismemberment Certificate. Written notice of such dismemberment or loss must be furnished within twenty days after the date of the accident causing such dismemberment or loss.

Replacing of Lost Certificates

Employees who lose any of their individual insurance certificates may, by completing Form G.L.I.-155, obtain duplicate certificates. These forms can be secured from your foreman.

Change of Name

If an employee legally changes his name for any reason, he should obtain from his foreman Form G.L.I.-42 and after filling it out, attach it to his insurance certificates and send it back to his foreman for further handling. The Insurance certificates will be endorsed by the Metropolitan Life Insurance Company and returned to the employee through the usual channels. In the event of a change of name by marriage of a female employee the form should be handled in the same manner as outlined above. Form should be completed in ink.

Change of Beneficiary

Employees may at any time change their beneficiary by obtaining from their foreman or department head Form G.L.I.-20. This form, properly completed in ink, together with the certificates, should be sent through the regular channels for proper endorsement by the METROPOLITAN LIFE INSURANCE COMPANY. They will change their records and the certificates will be returned to the employee. It is suggested that the nearest relative of the employee be named as beneficiary. It should be remembered that this insurance is for the benefit of the employee and his immediate family.

Health Service

The METROPOLITAN LIFE INSURANCE COMPANY maintains at many of the stations where our employees live a Visiting Nursing Service. The services of these nurses will be extended to our insured employees without cost to them. In case an insured employee becomes ill or injured, he may call to his home one of these trained graduate nurses who will carry out the doctor's instructions, and aid his family in seeing that he gets the proper care. The nurse will not stay in the home, as she is a Visiting Nurse, but she will return just as often as she is needed.

There will be distributed to insured employees at regular intervals valuable booklets prepared for insured employees and their families by the

METROPOLITAN LIFE INSURANCE COMPANY on the subjects of Health Conservation and Sickness Prevention. Below are some of the Welfare Booklets to which insured employees are entitled:

Accidents in the Home
All About Milk
Are You a True American?
Baby Circular
Cancer
Care of the Teeth
Child, The
Child Health Alphabet
Cook Book
Diphtheria
Eyesight and Health
First Aid in the Home
Fly Circular
Fly Swatters
Get Rid of Rats
Hook Worm
How to be Happy and Well
How to Dress the Baby
How to Live Long
How to Take Out Your First Citizenship Papers
How to Take Out Your Second Citizenship Papers
Infantile Paralysis
Influenza
Lady with the Lamp
Malaria
Measles
Pellagra
Prevention of Pneumonia
Red Trail of the Automobile
Scarlet Fever
Stamp Out Small Pox
The Wisdom of Professor Happy
Tonsils and Adenoids
Tuberculosis is Preventable
Typhoid Fever
War on Consumption
What Do I Spend
Whooping-cough
Why Die?
Who Loved Best?

Metropolitan Life Insurance Company Form 084 Group D.O.

PROOF OF DEATH

STATEMENT OF EMPLOYER

To the Metropolitan Life Insurance Company:
Claim Division.

City.....

Group Number.....Serial Number.....Date of Certificate.....Amount of Insurance $.....

This is to certify that.....(Name of Employee) died on the.....day of.....192....

and was in the employ of the undersigned at the date of death.

That the deceased had been so employed from.....to.....192....

And last reported for work on.....192....

Name of Beneficiary.....Relationship.....Age.....

Residence: No. and Street.....City or Town.....State.....

Was deceased cared for by the Company's Nursing Service during last illness?.....

Employer.....

Dated.....192....

By.....(Official Representative of Employer)

Send Claim Check to.....at.....

ATTENDING PHYSICIAN'S STATEMENT

As the Company preserves a record of its mortality experience, the report of the Attending Physician will be of great service if precise and full answers are given to the following questions.

Note.—If no attending physician, or in case of sudden death by accident or otherwise, attach certified copy of the record of death as shown by the books of the Health Department, Registrar, County Clerk or other officer having charge of such records.

1. Full Name of Deceased?

2. Date of Death?
Month.....Day.....Year.....

3. Place of Death? If death occurred in a hospital or institution, give its name.
No.....Street.....
City or Town.....State.....

4. Cause of Death?
.....
Duration from personal knowledge.....Yrs.....Mos.....Days
Duration from history given.....Yrs.....Mos.....Days
Contributory / Secondary
(Duration).....Yrs.....Mos.....Days

5. How long had deceased been ill when you were called to attend in last illness?

6. Date of your first visit in last illness?

7. Date of your last visit?

8. Was death caused by any condition arising from decedent's occupation?

9. Was death due to suicide, homicide or accident? If accident, give particulars and date.

I Hereby Certify that I attended the Deceased from.....to.....197....; that I signed the Certificate on file at the office of the Board of Health or Register of Vital Statistics, and that the answers as above recorded are complete and true to the best of my knowledge and belief.

Signature of Physician.....

Dated.....192....

Residence: No. and Street.....City or Town.....State.....

This is a fac-simile of form used in making proof of death referred to on page 8.

PREMIUMS MUST BE REGULARLY PAID WHILE DRAWING BENEFITS Form G.H.562 Apr. 1917

METROPOLITAN LIFE INSURANCE COMPANY

(Incorporated) 1 Madison Avenue, New York

GROUP DIVISION

FOR HOME OFFICE ONLY
Claim No.....Group.....Serial.....
Dated Cert. .....Age at Issue.....Sex.....
Effective on.....Benefit due.....
Weekly benefit $.....Post pay't made.....
Amount $.....For.....Weeks.....Days
Date of last pay't.....Total paid $.....
Covering.....Weeks.....Days

TO BE COMPLETED BY THE INSURED

After this form has been completed by you and by your Attending Physician please send to your employer.

Full name.....

Address.....Street.....City.....State

Employed by.....In the Capacity of.....

1. Date of Birth.....Age nearest Birthday.....Single / Married
2. Are you unable to do any and every part of your work?
3. If able to perform some of your duties, what are they?
4. What is the disease or condition which is causing this disability?
5. When were you first treated by a physician? (Give day and hour)
6. Name and address of physician in charge of your case.....Name.....Street.....City and State
7. Has treatment been discontinued?
8. If not, give dates of subsequent visits.....
9. If disability was caused by accident, give full information as follows.
Name parts of body injured.....
Nature of injury.....
How did accident happen?.....
Where and when did accident happen? Place.....Time.....Date.....
Name and full address of one witness.....
10. When were you first unable to work? At.....o'clock.....M.
11. Where were you at that time?
12. Are you receiving benefits for this disability from any Society, Lodge or other organization?
13. If so, name organization and state how much, and for how many weeks will benefit be paid?.....
14. When do you expect to be able to perform your duties?.....

I affirm that the above statements are true and complete to the best of my knowledge.

Date.....19....

.....Claimant

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

THIS IS TO CERTIFY that I first treated.....

at.....on.....19....at.....o'clock.....M

for.....

(Please give full statement of cause for Disability.)

complicated with.....

that.....has since been continuously under my care. (If not, please give dates of subsequent visits.....

he or she

and that.....is unable to perform.....Action.....

he or she totally or partially he or she

I expect that he/she will be able to return to work on.....19....

Date.....19....

.....M.D.

.....Address

TO BE COMPLETED BY THE EMPLOYER

THIS IS TO CERTIFY.....is employed by the undersigned as.....

That he/she was first absent on.....19.....and has been totally incapacitated since that date. Average earnings (if paid hour rate state hours per week).....per week.....

If disability is due to accident sustained in course of regular duties, give full particulars.....

Has accident been reported to the State Board or Commission acting under the State Workmen's Compensation Law?.....

If so, when?.....Has an award been made?.....How much.....per week? $.....How many weeks?.....

Has Employee returned to work?.....If so, exact date?.....

Date.....19....

.....Employer.

This is a fac-simile of form used to apply for payments for health and accident benefits referred to on page 9.

This form should be completed by the Employer the day the employee returns to duty, and mailed at once to the Group Health Division, Metropolitan Life Insurance Company, 1 Madison Avenue, New York City.

Form G.H.89C
June, 1928
PRINTED IN U.S.A.

METROPOLITAN LIFE INSURANCE COMPANY

(INCORPORATED BY THE STATE OF NEW YORK)

ADVICE ON RETURN OF ABSENT EMPLOYEE

.....192..

Name of Employee .....Serial No.....

Group Division (Health Insurance)

The above named returned to his/her duties this day.....192....., having been absent on account of.....his/her is apparently in good physical condition and working on full time and for full pay.

.....

.....
Employer

FOR HOME OFFICE USE ONLY
Claim Section.....
Renewal Section.....

This is a fac-simile of form used to give notice of return to work.