

Puget Sound Electrical Workers Healthcare Trust

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Administered by
Welfare & Pension Administration Service, Inc.

MATERNITY BENEFITS APPLICATION

TO BE COMPLETED BY THE EMPLOYEE

EMPLOYEE NAME	DATE OF BIRTH	SOCIAL SECURITY# or WPAS ID#	
HOME ADDRESS	CITY	STATE ZIP	TELEPHONE NO.
EMAIL ADDRESS			
CURRENT OR LAST EMPLOYER:	REQUESTED BENEFITS START DATE: (YOU MUST STOP WORKING ON OR BEFORE YOUR REQUESTED BENEFIT START DATE. IF YOU ARE WORKING YOU DO NOT QUALIFY FOR THIS BENEFIT)		
ARE YOU CURRENTLY COVERED UNDER THE HEALTH TRUST? <input type="checkbox"/> YES <input type="checkbox"/> NO ARE YOU CURRENTLY WORKING? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, PLEASE PROVIDE LAST DATE WORKED: IF YES, DO YOU HAVE AN INTENDED DATE TO STOP WORKING?	HAVE YOU DELIVERED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHAT WAS THE DELIVERY DATE? IF NO, WHAT IS THE DUE DATE?		
HAS A DOCTOR ORDERED YOU TO STOP WORKING DUE TO PREGNENCY AND/OR CHILDBIRTH? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, IN ADDITION TO THIS FORM, PLEASE COMPLETE WEEKLY TIMELOSS APPLICATION INCLUDING PHYSICIAN CERTIFICATION		

THIS SECTION TO BE COMPLETED BY EMPLOYEE: STATE PAID FAMILY MEDICAL LEAVE (SUCH AS WA-PFMLA)

DO YOU WORK IN THE STATE OF WA? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YOU WORK IN WA, DO YOU QUALIFY FOR WA- PFMLA? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, PROVIDE DOCUMENTATION OF REASON YOU DON'T QUALIFY:
IF YES, DID YOU APPLY FOR BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO
TO EMPLOYEE: IF YOU QUALIFY FOR PFMLA YOU MUST APPLY WITH THE STATE. THE PLAN WILL OFFSET YOUR WEEKLY MATERNITY BENEFIT BY PFMLA BENEFITS YOU QUALIFY FOR, EVEN IF YOU HAVE NOT APPLIED FOR THEM.
PLEASE ENCLOSE AWARD LETTER AND PFMLA WEEKLY BENEFIT AMOUNT:
PFMLA START DATE: _____ PFMLA END DATE: _____ IF YOU HAVE QUESTIONS ON YOUR BENEFIT AMOUNT, PLEASE GO TO: https://paidleave.wa.gov/

IF YOU WORK IN A STATE OTHER THAN WA, DOES STATE HAVE ANY PAID FAMILY MEDICAL LEAVE BENEFITS? YES NO
IF YES, PLEASE PROVIDE VERIFICATION.

THIS SECTION TO BE COMPLETED BY EMPLOYER (Federal FMLA verification)

DOES THE EMPLOYEE QUALIFY FOR FMLA?
 YES NO

IF NO, PROVIDE REASON FOR NOT QUALIFYING:

IF YES, HAS THE EMPLOYEE APPLIED AND BEEN APPROVED FOR FMLA BENEFITS?
 YES NO

FMLA START DATE:

FMLA END DATE:

IF EMPLOYEE HAS APPLIED AND FMLA HAS NOT BEEN APPROVED, PLEASE EXPLAIN:

NOTE TO EMPLOYEE: IF YOU QUALIFY FOR FMLA YOU MUST APPLY WITH YOUR EMPLOYER. IF FMLA IS NOT APPLIED FOR, YOU MAY LOSE YOUR HEALTHCARE COVERAGE UNDER THE TRUST.

EMPLOYER VERIFICATION
SIGNATURE OF EMPLOYER:

DATE:
TITLE OF SIGNER:

SIGN HERE ► _____
EMPLOYEE SIGNATURE

DATE SIGNED