# 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:<br><br>(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?<br>☐ YES ☐ NO<br><br>ARE YOU CURRENTLY WORKING?<br>☐ YES ☐ NO<br><br>IF NO, PLEASE PROVIDE LAST DATE WORKED:<br><br>IF YES, DO YOU HAVE AN INTENDED DATE TO STOP WORKING? | HAVE YOU DELIVERED?<br>☐ YES ☐ NO<br><br>IF YES, WHAT WAS THE DELVERY DATE?<br><br>IF NO, WHAT IS THE DUE DATE? |
| HAS A DOCTOR ORDERED YOU TO STOP WORKING DUE TO PREGENCY AND/OR CHILDBIRTH?<br>☐ YES ☐ 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? ☐ YES ☐ NO

IF YOU WORK IN WA, DO YOU QUALIFY FOR WA- PFMLA? ☐ YES ☐ NO

**IF NO, PROVIDE DOCUMENTATION OF REASON YOU DON'T QUALIFY:**

IF YES, DID YOU APPLY FOR BENEFITS? ☐ YES ☐ 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/)

<table>
<tr><td colspan="2">IF YOU WORK IN A STATE OTHER THAN WA, DOES STATE HAVE ANY PAID FAMILY MEDICAL LEAVE BENEFITS? ☐ YES ☐ NO<br><br>IF YES, PLEASE PROVIDE VERIFICATION.</td></tr>
<tr><td colspan="2">THIS SECTION TO BE COMPLETED BY EMPLOYER (Federal FMLA verification)</td></tr>
<tr><td>DOES THE EMPLOYEE QUALIFY FOR FMLA?<br>☐ YES ☐ NO</td><td>IF NO, PROVIDE REASON FOR NOT QUALIFYING:</td></tr>
<tr><td>IF YES, HAS THE EMPLOYEE APPLIED AND BEEN APPROVED FOR FMLA BENEFITS?<br>☐ YES ☐ NO<br><br>FMLA START DATE:<br>______________________<br><br>FMLA END DATE:<br><br>______________________</td><td>IF EMPLOYEE HAS APPLIED AND FMLA HAS NOT BEEN APPROVED, PLEASE EXPLAIN:<br><br>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.</td></tr>
<tr><td>EMPLOYER VERIFICATION<br>SIGNATURE OF EMPLOYER:<br><br>__________________________________________________<br>DATE:<br>TITLE OF SIGNER:</td><td></td></tr>
</table>

**SIGN HERE►** ________________________________________ ________________________________

EMPLOYEE SIGNATURE DATE SIGNED