NW Plumbers & Pipefitters Health Fund

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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 FULL TIMEON OR BEFORE YOUR REQUESTED BENEFIT START DATE. IF YOU ARE WORKING FULL TIME YOU DO NOT QUALIFY FOR THIS BENEFIT)		
ARE YOU CURRENTLY COVERED UNDER THE HEALTH TRUST? ☐YES ☐NO ARE YOU CURRENTLY WORKING? ☐YES ☐NO IF NO, PLEASE PROVIDE LAST DATE WORKED: IF YES, DO YOU HAVE AN INTENDED DATE TO STOP WORKING?	HAVE YOU DELIVERED? ☐YES ☐NO IF YES, WHAT WAS THE DELVERY DATE? IF NO, WHAT IS THE DUE DATE?		
HAS A DOCTOR ORDERED YOU TO STOP WORKING DUE TO PREGENCY AND/OR CHILDBIRTH? ☐YES ☐NO			

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