Electrical Workers Health & Welfare Fund

PARENTAL LEAVE BENEFIT Claim Form

Participant Information

Last Name ________________________________ First Name ___________________________Middle Initial _____

Social Security Number ____________________________________ Date of Birth ____________________________

Address

____

City ____ State ______________ Zip Code _____________

Phone (_________)________________________ Employer: ____

Child Information

Last Name ________________________________ First Name ___________________________Middle Initial _____

Social Security Number ____________________________________

Date of Birth_______________________________ OR Date of Adoption ___________________________

Dates of Parental Leave Take

From start date ________________ through end date ________________ Date returned to work ___________________

❑ I am the biological parent of the child listed above and have enclosed a copy of the birth certificate or birth notice/statement signed by the hospital OR I am the adoptive parent of the child listed above and have enclosed a copy of the adoption certificate.

❑ I certify that I am a covered active employee under the Plan and elect to begin my Parental Leave Benefit on __________________ (date).

❑ I understand that my Parental Leave Benefit ends the earlier of the date that I return to work or the date that the two week benefit is exhausted.

____ _________________________

Signature Date