Electrical Workers Health & Welfare Fund

MEMBER PREGNANCY LEAVE BENEFIT Claim Form

Member Information

Last Name _____ First Name _____ Middle Initial _____

Social Security Number _____ Date of Birth _____

Address _____

City _____State_____ Zip Code _____

Phone (_____)_____ Employer _____

☐ I certify that I am a covered active employee under the Plan and elect to begin my Pregnancy Leave Benefit on _____ (date).

☐ I understand that my Pregnancy Leave Benefit will cease as of the date eligibility is lost or I return to work.

Member Signature _____ Date Signed _____

Attending Physician Statement

Patient Name _____ Date of Birth _____

Pregnancy Estimated Due Date (if applicable)_____

Date of Delivery (if applicable)_____

Clinic/Hospital Name _____

Physicians Signature _____ Date Signed _____

Physicians Printed Name _____