SHEET METAL WORKERS (LOCAL UNION NO. 28)
SUPPLEMENTAL UNEMPLOYMENT BENEFIT PLAN
195 MINEOLA BLVD., MINEOLA, NEW YORK 11501
TEL.: (516)742-9478 FAX: (516)742-6360/8475
EMAIL: BENEFITS@LOCAL28FUNDS.COM

APPLICATION FOR MATERNITY BENEFITS

(Please Print)

NAME:_____
(Last) (First)

ADDRESS:_____
(No.) (Street) (Apt.#) (City) (State) (Zip)

LAST 4 DIGITS OF SS#: _____ TELEPHONE NO.: _____

WHAT IS YOUR EXPECTED DUE DATE OR ACTUAL DELIVERY DATE? _____/_____/_____

WHAT WAS THE LAST DATE YOU WORKED? _____/ _____/_____

WHEN DO YOU PLAN TO RETURN TO WORK? _____/_____/_____

WHEN DID YOU RETURN TO WORK IF YOU ALREADY WENT BACK? _____/_____/_____

I hereby certify that:

- I am/was unemployed in connection with a pregnancy and/ or birth of a child.
- I am submitting this completed application along with the signed certification from my physician who is licensed and certified in obstetrics. (See the back of this application for the physician's statement)
- All the foregoing information is complete, accurate and true.

DATE: _____ SIGNATURE: _____

YOU MUST RETURN THIS FORM ALONG WITH YOUR PHYSICIAN'S STATEMENT TO RECEIVE THIS BENEFIT.

A SUB PLAN APPLICATION MUST BE FILED NO LATER THAN **180 DAYS** FROM THE DATE OF SERVICE AND NO LATER THAN WEDNESDAY BEFORE **12:00PM** THE WEEK YOU APPLY.

Maternity Benefit Application

Attending Physician's Statement – To be completed and signed by the Attending Physician

I hereby certify that _____

Is pregnant with an estimated due date of _____/_____/_____.
or had a delivery date of _____/_____/_____

Physician's Verification:

Signed: _____, MD

Print Name: _____ Specialty: _____

Address: _____
_____

Telephone Number: _____