

# Northwest Plumbing and Pipefitting Industry Health, Welfare and Vacation 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:  (YOU MUST STOP WORKING FULL TIME ON 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? <input type="checkbox"/> YES <input type="checkbox"/> NO  ARE YOU CURRENTLY WORKING? <input type="checkbox"/> YES <input type="checkbox"/> NO  IF NO, PLEASE PROVIDE LAST DATE WORKED:   IF YES, DO YOU HAVE AN INTENDED DATE TO STOP WORKING?	HAVE YOU DELIVERED? <input type="checkbox"/> YES <input type="checkbox"/> NO  IF YES, WHAT WAS THE DELIVERY DATE?   IF NO, WHAT IS THE DUE DATE?		
HAS A DOCTOR ORDERED YOU TO STOP WORKING DUE TO PREGNENCY AND/OR CHILDBIRTH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
<b>THIS SECTION TO BE COMPLETED BY EMPLOYER (Federal FMLA verification)</b>			
DOES THE EMPLOYEE QUALIFY FOR FMLA? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF NO, PROVIDE REASON FOR NOT QUALIFYING:	
IF YES, HAS THE EMPLOYEE APPLIED AND BEEN APPROVED FOR FMLA BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO  FMLA START DATE: _____  FMLA END DATE: _____		IF EMPLOYEE HAS APPLIED AND FMLA HAS NOT BEEN APPROVED, PLEASE EXPLAIN:          <b>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.</b>	

<p>EMPLOYER VERIFICATION <b>SIGNATURE OF EMPLOYER:</b></p> <hr/> <p><b>DATE:</b> <b>TITLE OF SIGNER:</b></p>	
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**SIGN HERE ►** \_\_\_\_\_  
EMPLOYEE SIGNATURE

\_\_\_\_\_  
DATE SIGNED