DISTRICT COUNCIL 16
Northern California Health and Welfare Trust Fund
4160 Dublin Boulevard, Suite 400
Dublin, CA 94568-7756
Toll Free (800) 922-9902 Fax: (925) 833-7301
Email: Dc16info@hsba.com
www.dc16trustfund.org

DC16 MATERNITY LEAVE APPLICATION

PARTICIPANT DATA

LAST NAME	FIRST NAME		MI	DATE OF BIRTH / /
ADDRESS	CITY	STATE	ZIP	SEX	SOCIAL SECURITY # - -
EMAIL ADDRESS	TELEPHONE # ( )	CELL # ( )		Contact via text or email? Yes ☐ No ☐
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ DOMESTIC	DATE OF MARRIAGE or DIVORCE: / /	EMPLOYER:		LOCAL UNION #:

LEAVE DATA

MEDICAL PLAN: ☐ KAISER ☐ B.C	CERTIFICATE ATTACHED: ☐	TYPE OF EXPECTED DELIVERY: ☐ NATURAL ☐ C-SECTION

DATES OF LEAVE	FROM	TO	EXP DUE DATE			

Attach Doctor notes here or include with application:

Name: ____ **Signature:** ____________________________________ **STAMP:**____________

EMPLOYEES SIGNATURE AND DECLARATION:

YOUR FULL NAME: ______________________________ **SIGNATURE:** ______________________________ **DATE:** ______________

EMPLOYEE NOTES/INITIALS:

☐ ELIG APPROVED
☐ REIMBURSEMENT APPROVED

EMPLOYEE NOTES/ INITIALS:

☐ REIMBURSEMENT REQUSETED
☐ REIMBURSEMENT RECIEVED

Administered by: HS&BA