DISTRICT COUNCIL 16
Northern California Health and Welfare Trust Fund
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DC16 MATERNITY LEAVE APPLICATION

PART I. TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT ALL ANSWERS)

LAST NAME	FIRST NAME	INIT.	DATE OF BIRTH	SOCIAL SECURITY NUMBER

YOUR MAILING ADDRESS (NUMBER AND STREET, CITY, SATE, ZIP)	YOUR PHONE NUMBER

NAME OF COMPANY YOU WORK FOR	NAME OF YOUR DIRECT SUPERVISOR	EMPLOYER PHONE NUMBER

COMPANY'S PHYSICAL ADDRESS	LOCAL UNION NUMBER

MEDICAL PLAN:
- ☐ KAISER
- ☐ B.C

TYPE OF EXPECTED DELIVERY:
- ☐ NATURAL
- ☐ C-SECTION

DATES OF LEAVE:	FROM:	TO:	Expected DUE DATE

ATTACH FMLA/ OTHER GOVERNMENT GRANTS &
LAST CHECK/MOST RECENT PAYCHECK STUB

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief, true and correct and complete. I hereby authorize any physician, any hospital, the disability plan manager, or any worker's compensation carrier to furnish and disclose all facts concerning this disability. A copy or photocopy of this authorization shall be valid as the original. I agree that I will report all benefit amounts I am receiving, or entitled to receive, because of my disability. I understand that I must give written notice to the administration office when I recover from my disability, or when I become self-employed or employed by anyone.

EMPLOYEE SIGNATURE_____ **DATE:** _____

PART II. TO BE COMPLETED BY EMPLOYER (PLEASE PRINT ALL ANSWERS)

EMPLOYEES JOB CLASSIFICATION	# OF HOURS PER WEEK	LAST DATE WORKED:	EMPLOYEE HRLY WAGE RATE:

EMPLOYER NOTES:	RETURN DATE:

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EMPLOYER SIGNATURE_____ **DATE:** _____

EMPLOYER SIGN OFF NAME:_____ **Contact phone number:**_____ **Email:**

PART III. TO BE COMPLETED BY THE DOCTOR (PLEASE PRINT ALL ANSWERs)		
CLAIMANT IS/WAS CONTINUOUSLY DISABLED FROM_____THROUGH_____	5. IF STILL DISABLED, DATE CLAIMANT SHOULD BE ABLE TO RETURN TO WORK:	
DOCTOR'S NAME AND DEGREE (PRINT):	**DOCTOR'S SIGNATURE:**	**DATE SIGNED:**
DOCTOR'S STREET ADDRESS:		**DOCTOR'S OFFICE PHONE NUMBER:**

Paid Maternity Leave Program for Selected Participants:
The following participants are eligible for Paid Maternity Leave:

- Paid Maternity Leave is available only to you if contributions are made to the Fund on your behalf. Dependents of participants, such as spouses and children, are not eligible.
- You must have worked at least 100 hours over the past 3 months and currently are eligible for Fund coverage as of the date of your disability.
- You must not have used this benefit more than once within the past 24 months.
- [Pre-delivery leave only] You must be unable to perform the duties of your trade due to physical limitations associated with your pregnancy. You must submit certification from your physician to the Trust Fund Office, which verifies your inability to work due to these limitations.
- This program is unavailable for surrogate-related pregnancies, adoption of a child or foster care arrangements.
- Canadian residents are not eligible.

You will receive 2/3 of your weekly pay, up to $800 per week. Weekly earnings will be determined based on your hourly wage for a 40-hour work week. Benefits will be calculated at the rate of 1/7 of the weekly benefit for each day of total disability if you are totally disabled for less than one week. Benefit payments are calculated using the following formula: 66.67% of Normal Hourly Wage x 2080 ÷ 52 = Weekly Benefit ($800 cap).
Benefits from this Paid Maternity Leave Benefit will be coordinated with any benefits from the State of California, such as State Disability Insurance and Paid Family Leave. You will not receive more than 100% of your weekly pay from the combination of the maternity leave program, State Disability Insurance, Paid Family Leave or another governmental source.

There are two parts of the Paid Maternity Leave benefit, a pre-birth benefit and a post-birth benefit.
Pre-Birth Benefit

- Eligibility for this benefit will not begin before the 4th month of pregnancy. The cumulative pre-delivery/birth benefit may be intermittent but may not exceed 6 months. After 6 months, the benefit payments will stop regardless of whether you are able to return to work.
- You will need to submit recertification of your continued inability to work every 2 months, as provided by your physician during the pregnancy.

Post-Birth Benefit

- You will receive up to 6 weeks of paid leave after giving birth with an additional 2 weeks if you give birth by cesarean section

EMPLOYEES SIGNATURE AND DECLARATION:

YOUR FULL NAME:	**SIGNATURE:**	**DATE:**
_____	_____	_____

EMPLOYEE NOTES/INITIALS:

☐ ELIG APPROVED
☐ REIMBURSEMENT APPROVED

EMPLOYEE NOTES/ INITIALS:

☐ LMCI REIMBURSMENT REQUSETED
☐ LMCI REIMBURSEMENT RECEIVED

EMPLOYEE CALCULATION NOTES: