SAN FRANCISCO ELECTRICAL WORKERS
HEALTH & WELFARE PLAN

Application for Pregnancy Leave Benefit

Instructions: Complete this form and return it to EISB to claim Pregnancy Leave Benefits as described in the Plan document and Summary Plan Description.

Member Name: _____ Member SS# (last 4 digits only): _____

Address: _____

Telephone: (H) _____ (C) _____

Date Leave Began: _____ Date Leave Ended: _____

Eligibility Requirements:

- □ You are an IBEW Local 6 member in good standing.
- □ You have current health (including COBRA) coverage under the Plan.
- □ You are unable to work due to pregnancy or post-partum disability and recovery. (Provide physician statement.)
- □ You have collected all available California State Disability Insurance and Paid Family Leave.

Member Certification:

I am the Member named above, and I hereby request that the Plan pay me Pregnancy Leave Benefits as described in the Plan for the leave period described above. I certify that:

- I have met all of the eligibility conditions listed above for the entire period of leave requested.
- I understand that Pregnancy Leave Benefits are subject to state and federal income and payroll taxes.
- I understand that I may be asked to provide further information about this application, and I agree to provide that information.

Member Signature: _____ Date: _____

Return this completed form to: EISB, 720 Market Street, Suite 700, San Francicso, CA 94102
TEL: (415) 263-3670