NECA IBEW
LEADING THE ELECTRICAL INDUSTRY

HARRISON TRUST

A FAMILY HEALTH PLAN
WWW.HARRISONBENEFITS.ORG

APPLICATION - FAMILY AND MEDICAL LEAVE (FMLA) & EXTENDED MATERNITY BENEFIT

Each employee who seeks benefits for Family and Medical Leave must complete all information requested. It is your responsibility to ensure that your employer completes the information as directed concerning your leave. It is your responsibility to ensure that the completed application is returned to the Harrison Electrical Workers Trust Fund. If you or your employer need additional space to complete a question, please attach an additional sheet of paper.

INSTRUCTIONS: For FMLA only, complete sections 1 & 2 only. For FMLA and the Extended Maternity Benefit complete sections 1, 2, & 3.

_____ _____
Full Name - Please Print Social Security Number

_____
Address City State Zip

_____ (_____)_____
Date of Birth Telephone

1. Are you participating in the Harrison Electrical Workers Trust Fund as a Category 1 or Category 2 employee:
(Check One) Category 1_____ Category 2 _____

2. Provide the name, address and telephone number of your current employer:

_____

Part 1 – Completed by the Employee

3. Have you already applied to your employer for family and medical leave? (Check One) Yes ____No _____
If your answer to question 3 is **yes**, answer the following questions:
   a) Was your request granted? Yes_____No_____
   b) Name/job title of the individual who granted or denied your request: _____
   c) If your request for leave was granted, when will it start? _____
   d) Do you intend to return to work for your employer following the FMLA? (Check One) Yes _____No _____

4. If your answer to question 3 is **no,** answer the following question:
   a) When do you intend to apply to your employer for family and medical leave? _____

5. Have you applied for Paid Leave Oregon/Washington? Yes _____No ____

6. Please state the basis for your application for family and medical leave:
(Check appropriate box)

- ☐ Birth of a child or placement of a child for adoption or foster care.
- ☐ To care for a spouse, child or parent with a serious health condition.*
- ☐ Your own serious health condition.*
- ☐ Your own Pregnancy – **Please be sure to complete section 2 & 3 below.**

I certify that the answers to the questions on this application form are true and correct.

_____ _____
Sign Your Name Date

PMB #116 • 5331 S Macadam Avenue • Suite 258, Portland, OR 97239
(503) 224-0048 (800) 547-4457 Fax (503) 228-0149

*A serious health condition is defined as an illness, injury or impairment, including: (i) inpatient treatment; (ii) absence from work or school for three or more days with continuing treatment by a health care provider; (iii) continued treatment by a health care provider or a condition which is incurable or serious enough to result in three or more days of incapacity; or (iv) parental care.

Part 2 – Completed by the Employer

1. Has_____applied to you for family and medical leave?
(insert applicant's name)
(check one) Yes _____No _____

2. State the period-of-time the employee will be off work for family and medical leave.

From:_____ To:_____

3. Indicate the total length of time _____has worked for your company: _____
(insert applicant's name)

(If this employee has worked for your company on several occasions, total all time worked.)

4. Has _____worked for your company at least 750 hours in the 12-month
(insert applicant's name)
period of time immediately preceding the family and medical leave? Yes _____ No_____

5. Please state the reasons(s) or condition(s) that resulted in your company granting family and medical leave to _____.
(insert applicant's name)

_____

_____

I certify that the answers to the questions on this application form are true and correct.

_____ _____
Sign your name Date

_____
Job Title

Part 3 – Completed by the Attending Medical Professional (For Maternity Benefit)

1. DATE FIRST CONSULTED YOU FOR THIS CONDITION:	2. DATE PATIENT ABLE TO RETURN TO WORK:	3. DATES OF TOTAL LEAVE: FROM: THROUGH:
4. DATE OF ESTIMATED BABY DELIVERY:		
5. SIGNATURE OF PHYSICIAN OR SUPPLIER: SIGNED DATE	6. ENTER THE TAXPAYER IDENTIFYING NUMBER TO BE USED FOR 1099 REPORTING PURPOSES. YOU ARE REQUIRED UNDER AUTHORITY OF LAW TO FURNISH YOUR TAXPAYER IDENTIFYING NUMBER:	7. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.: