U.A. LOCAL NO. 393 HEALTH AND WELFARE PLAN
Application for Paid Family Leave

Instructions to Applicant to File a New Claim

- Complete the below Paid Family Leave application
- Attach a copy of proof of payment from the State Benefits (i.e. a screenshot or printout of your payment from the EDD website). Proof must include Benefit Week Ending Date, your name, and the amount paid.
- Fax or mail the completed application and necessary documents to:

U.A. Local 393 Trust Funds
Paid Family Leave Benefit
P.O. Box 2460
San Jose, CA 95109

or

Fax #: (408) 493-0232
Email: staff@ualocal393benefits.org

Name: _____ Social Security No.: _____

Address: _____ Date of Birth: _____

_____ Phone Number: _____

_____

Classification: _____ Email: _____

Last Day Worked _____

Leave Begin _____

Leave End _____

Reason for Leave _____

Name of Person you are caring for/Relationship) _____

I hereby apply for Paid Family Leave Benefits. I acknowledge, under penalty of law, that I am entitled to benefits for a particular week only if I submit proof that I am receiving Paid Family Leave benefits from the State of California. I agree to notify the U.A. Local 393 Trust Fund immediately if I am no longer eligible for State benefits.

Signature: _____ Date: _____
