

# I.U.P.A.T. Welfare Fund

## Maternity Benefit Claim Form

Return completed form to:

I.U.P.A.T. Welfare Fund  
 P.O. BOX 99459  
 Troy, MI 48099-9998

Phone #: (330) 779-8865  
 Fax #: (248) 556-2596  
 Email: stdisability@benesys.com

***TO ENSURE PAYMENT OF MATERNITY LEAVE BENEFITS, THIS FORM MUST BE COMPLETED/FILED WITH I.U.P.A.T WELFARE FUND.***

Pregnant Employee's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Approximate Due Date: \_\_\_\_\_ Expected Delivery (circle): Vaginal or C-section

### PRE-DELIVERY BENEFITS

(For complications up to 6 months prior to delivery)

I, (Print Name of Treating Physician) \_\_\_\_\_ certify that the participant is unable to perform the duties of their job due to physical limitations listed below arising from their pregnancy:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Nature of surgical or obstetrical procedure prior to Delivery, if any (Describe fully):

\_\_\_\_\_  
 \_\_\_\_\_

Participant has been unable to work prior to her delivery due to complications of pregnancy:

From: \_\_\_\_\_ Through: \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### POST-DELIVERY BENEFITS

(Up to six weeks for Vaginal Delivery, or eight weeks for a C-section)

**Date of Delivery:** \_\_\_\_\_ **Type of Delivery:** \_\_\_\_\_

Expected Return to Work Date: \_\_\_\_\_

Date: \_\_\_\_\_ Physician's Name (Print): \_\_\_\_\_

Degree

**Physician's Signature:** \_\_\_\_\_

Address: \_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_ Physician's Fax Number: \_\_\_\_\_

## I.U.P.A.T. Welfare Fund

### Paid Maternity Leave Program

**TO BE ELIGIBLE FOR THIS BENEFIT, THE FOLLOWING CRITERIA MUST BE MET:**

- ✓ A certification must be submitted by a medical doctor verifying the Participant is unable to perform the duties of their trade due to physical limitations arising from their pregnancy (Pre-Delivery Benefits only);
- ✓ At the time the application is made under this Benefit Program the Participant is eligible for coverage under the Plan; and
- ✓ The Participant has not used this Benefit within the past twenty-four (24) months.

**EXCEPTIONS/LIMITATIONS - This Benefit is *not* available to:**

- Canadian residents
- Members who are not an Active Participant for Plan benefits
- Surrogate-related pregnancies
- Adoption of a child
- Foster care situations
- Dependents of the Participant

**AVAILABLE BENEFITS:** The Benefit Program provides benefits for pregnancy (pre-delivery/birth) for a maximum of six months and post-delivery/birth for a maximum benefit of six weeks for a vaginal birth, or eight weeks for cesarean birth. **Regardless of what was covered under the pre-delivery Benefits, a Participant will be eligible for up to six weeks of paid leave after childbirth with two additional weeks of paid leave Benefits available for cesarean deliveries.**

- ❖ **Pregnancy** (pre-delivery/birth) - Six-month maximum benefit for Paid Maternity - Participant must meet the eligibility criteria, but eligibility for this Benefit shall not begin until the onset of the fourth month of pregnancy. This pre-delivery/birth benefit may be intermittent and may not exceed six months. After six months the Benefits will stop regardless of whether the Participant is able to return to work or not. From time to time, the Plan may require re-certification of continued inability to work by the Participant's medical doctor during pregnancy.
- ❖ **Post-Delivery/Birth** - six weeks maximum benefit or eight weeks maximum benefit for cesarean birth.

**Benefits are paid weekly and are equal to 66.67% of the Participant's normal weekly earnings to a maximum weekly Benefit of \$800. Weekly earnings shall be determined to be the normal hourly wage based on a forty-hour work week.** Benefit payments under this Benefit Program shall not be considered "other income" for purposes of determining the Participant's eligibility for other Plan benefits.

**\*Please be sure to include a copy of your most recent paystubs.**