RHODE ISLAND LABORERS' BENEFIT FUNDS | LiUNA!

HEALTH FUND

UNION TRUSTEES

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EMPLOYER TRUSTEES

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ADMINISTRATOR

Valerie E. Campana

Application for Sick or Safe Leave Benefit

Please read and answer all questions carefully. Please print all answers. Be sure to sign and date the application. Mail or deliver the application to the Fund Office at the address listed below. This application may be submitted no more than one calendar month after the date(s) of leave or, for foreseeable leave, no more than one calendar month before the date(s) of leave.

Name

_____

(First) (Middle) (Last)

Address

_____

(Street) (City) (State) (Zip)

Telephone _____ Social Security Number _____

Date of Leave: _____ ☐ 4 hours ☐ 8 hours

Date of Leave: _____ ☐ 4 hours ☐ 8 hours

Date of Leave: _____ ☐ 4 hours ☐ 8 hours

Date of Leave: _____ ☐ 4 hours ☐ 8 hours

Date of Leave: _____ ☐ 4 hours ☐ 8 hours

On the dates listed above, for the amount of time indicated, I am or was:

(Check one:)

☐ Scheduled to work for

_____

(Name of Employer)

OR

☐ Listed on the LIUNA Local 271 referral list and available for work

but unable to work for one of the following reasons:

- I was ill or injured and unable to work due to my illness or injury;
- I had a medical appointment;
- I accompanied a family member to a medical appointment;
- I needed to care for a family member who was ill or injured or under quarantine;
- My workplace was closed due to a public health emergency;
- I needed to care for my child because my child's school or day care was closed due to a public health emergency; or

- I was unable to work for reasons related to the domestic violence, sexual assault, or stalking of me or my family member.

Family member means your child, parent, spouse, parent-in-law, grandparent, grandchild, sibling, domestic partner, and any other individual for whom you provide care or who is a member of your household.

If my request for leave is for more than three consecutive days, the Fund Office may in its discretion require me to provide documentation of my need for leave. If the Fund Office has determined in its discretion that I have established a clear pattern of taking leave on days just before or after a weekend, vacation, or holiday, the Fund Office may require me to provide documentation of my need for leave.

I did not or will not receive temporary disability insurance, temporary caregiver insurance, or workers' compensation benefits for these days.

The above statements are true to the best of my knowledge and belief. I understand that a false statement may disqualify me for benefits and that the Trustees have the right to recover any payments made to me because of a false statement. I have notified the identified employer or business manager that I was or am unable to work as scheduled.

Signature _____Date _____

Form W-4 must be completed and returned with the application. If Form W-4 is not received, taxes will be withheld based on single with no dependents.

Authorization for Release of Protected Health Information

To the extent that the information provided herein constitutes Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA), I hereby authorize the use or disclosure of this information to representative(s) of the employer identified to verify that I was scheduled to work and did not work on the date(s) indicated for the employer identified. I understand that this authorization is voluntary and that I have the right to revoke this authorization at any time by notifying the Fund Office in writing at the address noted above. I understand that such a revocation is only effective after it is received and logged by the Fund Office. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by a revocation. This authorization will expire one year from the date of my signature.

Signature _____Date _____