LIUNA Maternity Disability Plan

Application for Post-Birth Disability Benefits

For Members of the Laborers' International Union of North America

Upload Forms at www.liuna.org/maternitydisability

Mail or scan/email completed form to:
Plan Administrator, LIUNA Maternity Disability Benefit Plan, 905 16th Street, NW, Washington, DC 20006
Email: maternitydisability@liuna.org
Questions: Use email above or call Rebecca Rougier at 202-403-8041

This form is for: ☐ Initial request for post-birth benefits ☐ Supplemental information

☐ Check here if new address or email

SECTION A	TO BE COMPLETED BY THE LIUNA MEMBER			
MEMBER NAME	DATE OF BIRTH	MEMBER NO.	LOCAL NO.	LAST 4 OF SOCIAL SECURITY NO. XXX-XX-_____
HOME ADDRESS	CITY	STATE	ZIP	TELEPHONE NO.
EMAIL				

A. Expected Birth Date: _____

B. Are you also requesting benefits prior to your expected birth date? ☐Yes ☐No

C. If Yes, requested dates for pre-birth benefits: From: _____ To: _____

D. Reason for requested post-birth benefits: _____

E. Medical complications (if any) justifying extension up to 2 weeks: _____

F. Name of your most recent Employer: _____

G. Name of your doctor or other medical provider: _____

MEMBERS SEEKING POST-BIRTH BENEFITS MUST SUBMIT COPY OF BIRTH CERTIFICATE

"I hereby authorize my Physician, Hospital, Pharmacy, Insurance Company, Employer, Health & Welfare Plan Administrator, or Local Union to release any information regarding the medical, mental, treatment or benefits payable including disability or employment related information concerning this claim to the Plan Administrator of the LIUNA Maternity Disability Plan or its authorized agent for the purpose of validating and determining benefits payable in connection with this claim. This data may be used in audits or for statistical purposes, but without identifying information such as SSNs or DOBs."

"I HEREBY CLAIM POST-BIRTH MATERNITY DISABILITY BENEFITS AND CERTIFY THAT FOR THE PERIOD COVERED BY THE CLAIM I WAS DISABLED FROM WORKING; AND THAT THE FOREGOING STATEMENTS, INCLUDING ANY ACCOMPANYING STATEMENTS, ARE TO THE BEST OF MY KNOWLEDGE TRUE AND COMPLETE."

SIGN HERE► _____

LIUNA MEMBER SIGNATURE DATE SIGNED

SECTION B	FOR THE MEMBER'S LIUNA-AFFILIATED HEALTH & WELFARE FUND	
MEMBER NAME	MEMBER NO.	LOCAL NO.
IS LIUNA MEMBER ELIGIBLE FOR H&W BENEFITS? ☐ Yes ☐ No	IF NOT ELIGIBLE, PLEASE STATE REASON:	IF ELIGIBLE, THRU WHAT DATE: __ / __ /_____
OPTION: LIUNA-AFFILIATED HEALTH & WELFARE FUNDS MAY ANSWER ABOVE QUESTIONS BY EMAIL TO maternitydisability@liuna.org		

SIGN HERE► _____

H&W FUND REPRESENTATIVE SIGNATURE DATE SIGNED

_____

PRINTED NAME JOB TITLE NAME OF H&W FUND TELEPHONE NUMBER

SECTION C TO BE COMPLETED BY THE LIUNA MEMBER				
MEMBER NAME	DATE OF BIRTH			
HOME ADDRESS	CITY	STATE	ZIP	TELEPHONE NO.
EMAIL				

SECTION C TO BE COMPLETED BY DOCTOR OR OTHER MEDICAL PROVIDER	
PATIENT'S NAME:	AGE:
DIAGNOSIS (ICD10):	IF HOSPITALIZED, GIVE DATE OF ADMIT:
APPROXIMATE DELIVERY / BIRTH DATE:	
THIS WILL CERTIFY PATIENT IS/WAS CONTINUOUSLY UNABLE TO WORK DUE TO PHYSICAL LIMITATIONS ARISING FROM PREGNANCY: FROM: TO:	LAST DATE WORKED:
IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK:	MEDICAL COMPLICATIONS JUSTIFYING 2-WEEK EXTENSION:
MEDICAL PROVIDER'S NAME (PRINT) DEGREE	TELEPHONE
STREET ADDRESS	CITY – STATE – ZIP CODE

SIGN HERE► _____

DOCTOR OR OTHER MEDICAL PROVIDER DATE SIGNED