MEMBER-2-MEMBER FUNDS MATERNITY BENEFIT

PAID MATERNITY LEAVE
WEEKLY TIME LOSS CLAIM FORM

SECTION A	TO BE COMPLETED BY MEMBER			
EMPLOYEE NAME	DATE OF BIRTH		SOCIAL SECURITY NUMBER	
HOME ADDRESS	CITY	STATE	ZIP	TELEPHONE NO.
EMAIL ADDRESS				

1. **EXPECTED DELIVERY DATE:** ________________________________
2. **TYPE OF LEAVE REQUESTED:** ☐ **PRE-DELIVERY OR** ☐ **POST-DELIVERY (CHECK ONE)**
3. **REQUESTED LEAVE DATE:** ________________________________
4. **REASON(S) FOR REQUESTED LEAVE:** ________________________________

   ____
5. **NAME AND ADDRESS OF YOUR DOCTOR:** ________________________________

   ____

IF YOU ARE HOSPITALIZED OR HAVE DELIVERED:

6. **NAME AND ADDRESS OF HOSPITAL OR CARE FACILITY:** ________________________________

   ____
7. **DATE ENTERED HOSPITAL OR CARE FACILITY:** ________________________________
8. **DELIVERY DATE (IF APPLICABLE):** ________________________________

HIPAA AUTHORIZATION: I hereby authorize any Physician, Hospital, Insurance Company, Employer, Health Plan Administrator or Local Union Organization to release any information regarding the medical history, treatment or benefits payable (including disability or employment related information) related to my pregnancy to the Operative Plasterers' & Cement Masons' International Association or its authorized agent for the purpose of validating and determining benefits payable in connection with this claim. This authorization will terminate on the last date on which benefits are payable. I understand that I have a right to revoke this authorization, in writing and at any time, except where uses and disclosures have already been based upon my original permission. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that medical records and information used or disclosed with my permission may be re-disclosed and no longer protected by the privacy provisions of the Health Insurance Portability and Accountability Act. I understand that I or my authorized representative will receive a copy of this authorization upon request. A copy of this authorization is as valid as the original.

SIGN HERE► ________________________________ ________________________________

APPLICANT DATE SIGNED

CONTINUED ON REVERSE SIDE

SECTION B — TO BE COMPLETED BY MEMBER

1. HAVE YOU APPLIED FOR OR RECEIVED ANY PAID MATERNITY LEAVE THROUGH THE GOVERNMENT, YOUR EMPLOYER, LOCAL UNION OR LOCAL UNION HEALTH AND WELFARE FUND?

☐ **YES**

☐ **NO**

2. IF YOUR ANSWER TO QUESTION NUMBER 1 IS "YES," PLEASE IDENTIFY THE SOURCE, AMOUNT AND DURATION OF THE BENEFIT:

SOURCE:	**AMOUNT:**	**DURATION:**

SIGN HERE► ______________________________ ______________________

APPLICANT DATE SIGNED

NOTE: By signing above, the applicant certifies that the information is correct and understands that providing inaccurate information may lead to ineligibility for benefits under the Member-2-Member Funds' Paid Maternity Leave Program.

SECTION C — TO BE COMPLETED BY LOCAL UNION

EMPLOYER:	**LOCAL UNION NO.**
JOB CLASSIFICATION:	**GROSS BASIC WEEKLY EARNINGS**
DATE LAST WORKED:	**DATE RETURNED TO WORK (IF APPLICABLE)**
WAS THE APPLICANT A MEMBER ON THE DATE OF INJURY?	

SIGN HERE► ______________________________ ______________________

AUTHORIZED REPRESENTATIVE DATE SIGNED

SECTION D — TO BE COMPLETED BY TREATING PHYSICIAN

PATIENT NAME:		AGE:
DIAGNOSIS:		IF HOSPITALIZED, DATE OF ADMIT:
APPROXIMATE DELIVERY/BIRTH DATE:	IS LEAVE REQUEST RESULT OF INJURY/ACCIDENT OR SICKNESS/ILLNESS? YES ☐ NO ☐	
PATIENT IS/WAS CONTINUOUSLY UNABLE TO WORK DUE TO PHYSICAL LIMITATIONS ARISING FROM PREGNANCY FROM: TO:		LAST DATE WORKED:
IF STILL DISABLED, DATE ABLE TO RETURN TO WORK:		DATE RETURNED TO WORK:
DATE	PHYSICIAN'S NAME (PRINT)	DEGREE
STREET ADDRESS	CITY/STATE/ZIP	

SIGN HERE► ______________________________ ______________________

TREATING PHYSICIAN DATE SIGNED

PROCEDURE FOR FILING MATERNITY BENEFIT CLAIM

1. Fill out Section A with required information, complete with your signature.
2. Fill out Section B with required information, complete with your signature.
3. Have your Local Union complete and sign Section C.
4. Have your treating physician fill out Section D.
5. Mail, email, or fax the completed Claim Form to:

Member-2-Member Maternity Leave Program
9700 Patuxent Woods Drive, Suite 200
Columbia, MD 21046
Fax: (301) 623-1097
Email: M2MAdministrator@opcmia.org