Insulators and Allied Workers National Medical Fund

2010 N.W. 150th Avenue, Suite 200 | Pembroke Pines, FL 33028
Toll Free: (888) 352.0629 | West Coast Toll Free: (888) 987.0629
Fax: (954) 266.2079 | www.nebainc.com

Administered by:
NATIONAL EMPLOYEE BENEFITS ADMINISTRATORS, INC.
NEBA

WEEKLY DISABILITY BENEFIT FORM FOR PREGNANCY AND MATERNITY LEAVE

Dear Participant:

In order to receive the weekly disability for pregnancy and maternity leave, please complete the following information and return to the Fund Office.

1. Participant Information

Participant Name: Last 4 SSN:

Participant Date of Birth: Phone Number:

Address:

2. Pre-birth Pregnancy Benefit Information

For pre-birth pregnancy benefit, a legally qualified physician or certified nurse midwife must certify that you are unable to work. A signed letter from the physician should be attached with start date of pregnancy leave. Additional comments may be entered in the box below..

Physician/Nurse Comments:

_____

_____

_____

Physician Signature: _____ Date: _____

3. Post birth Maternity Benefit Information

For post birth maternity benefit, the participant must complete the following information. A physician/nurse certification is not required.

Date of newborn: _____

Please check one: ___ Natural Child Birth ____Cesarean Section

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Natural child birth benefit is payable for up to 6 weeks, and cesarean section birth is payable up to 8 weeks. Participant does not qualify for this benefit if they are receiving weekly accident and sickness benefit, any other wage replacement benefits, paid leave through an employer, state, or local government, or other means.

By signing below, I attest that the above answers are true and complete according to the best of my knowledge and belief.

Participant Signature: _____ Date: _____