Maternity Benefit Plan Administrator
c/o General Secretary Treasurer
United Association
Three Park Place
Annapolis, MD 21401
(443) 808-1731 or (410) 269-2000 ext. 5088

United Association Maternity Benefit Claim Form – UNITED STATES

CLAIMANT INFORMATION

UA Member ID Number			
Member's Name (First)	(Middle)	(Last)	Date of Birth (mm/dd/yyyy)
Home Address (Street)	(City)	(State)	(Zip)
Home Telephone No.	Cell Telephone No.	Email Address	
UA Local Union (Local Number, Town/City, State)			

ELIGIBILITY FOR THE MATERNITY BENEFIT

What is the date you gave birth to your child (or children, for multiple births)?

As of the date of your child(ren)'s birth, were you a member in good standing of the UA? _____ (yes or no)

DOCUMENTATION

Please include the following documents with this application:

- Copy of the birth certificate(s)

FRAUD WARNING

By signing the Member Certification below, you acknowledge and understand that any false statement made by you in this Claim Form or any fraudulent information or proof you furnish will impede your claim. You further understand that if you have made any false statement or provided fraudulent information or proof, you will be liable to the UA Maternity Benefit Plan for any expenses incurred by the Plan in relying on such statement, information, or proof. The Plan shall have the right to recover any payments made to you because of a false statement, including interest.

MEMBER CERTIFICATION

I HEREBY CERTIFY THAT I GAVE BIRTH TO A CHILD OR CHILDREN (IF MULTIPLE BIRTHS) AND THAT THE FOREGOING STATEMENTS, INCLUDING ANY ACCOMPANYING STATEMENTS, ARE TO THE BEST OF MY KNOWLEDGE TRUE AND COMPLETE.

Member's Name (Print) **Signature** **Date**

▶ _____

IF I RECEIVE A MATERNITY BENEFIT GREATER THAN THAT WHICH I SHOULD HAVE BEEN PAID, I UNDERSTAND THAT THE UA MATERNITY BENEFIT PLAN HAS THE RIGHT TO RECOVER SUCH OVERPAYMENTS FROM ME, INCLUDING INTEREST ON ANY OVERPAYMENT, ATTORNEYS' FEES AND ALL COSTS INCURRED IN COLLECTION.

Member's Name (Print) **Signature** **Date**

▶ _____

I UNDERSTAND THAT THE PERSONAL INFORMATION I PROVIDE AS PART OF THIS APPLICATION IS BEING COLLECTED, USED AND RETAINED TO DETERMINE MY ELIGIBILITY FOR THE MATERNITY BENEFIT. I UNDERSTAND THAT THIS INFORMATION WILL ONLY BE DISCLOSED TO THOSE WHO ARE INVOLVED WITH DETERMINING ELIGIBILITY AND WITH ADMINISTERING THE MATERNITY BENEFIT. I UNDERSTAND THAT MY PERSONAL INFORMATION WILL BE STORED SECURELY AND, IF THERE IS A NEED TO DISCLOSE IT TO A THIRD PARTY, THE MATERNITY BENEFIT PLAN WILL REQUIRE THAT THIRD PARTY TO IMPLEMENT SIMILAR SECURITY MEASURES.

Member's Name (Print) **Signature** **Date**

▶ _____

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