IATSE 478 Family Leave Program
Financial Assistance Claim Form

I hereby apply for Financial Assistance with the IATSE Family Leave Program. I understand that the following information will be used in the determination of my eligibility for funds.

First Name: ______________________________ Last Name: ______________________________

Current Address: ____

City: ______________________ State: ______ Zip Code: __________

Mailing address (if different): ____

City: ______________________ State: ______ Zip Code: __________ Parish: ____________________

Home Phone: _____________________ Cell Phone: _______________________

Email address: ____

Best way to reach you: __________________________________

Please briefly explain why you are applying for Family Leave Financial Assistance:

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<u>Proof of Pregnancy, Birth, or Adoption of a New Child</u>

All documentation listed below will be provided at member's cost and should be submitted with a completed Claim Form via email to sect@iatse478.org or mailed to the IATSE 478 Welfare Committee at 511 N. Hennessey Street, New Orleans, LA 70119.

Please provide all documentation on this list that applies to you and your family situation:

- a physician's statement of pregnancy (with physician's contact information and member's name, address, and expected due date)
- a copy of the child's birth certificate
- documentation of legal adoption or guardianship which contains the member's name
- certified marriage license
- certified declaration of domestic partnership
- paternity test results from an AABB-accredited paternity testing service
- affidavit of acknowledgement of paternity
- documentation showing the member's engagement in the adoption process signed by the adoption agency or provider
- a copy of the judicial decree of adoption or legal guardianship

Please indicate which form(s) of documentation you will be providing:

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Benefits Duration

The period of time for which the member receives Benefits must be consecutive. It also must fall during the pregnancy and/or during the first six months following birth and/or placement for adoption or foster care. *This is intended to be financial assistance for when the member is not working in an IA-covered craft.*

Requested number of weeks of benefits (the maximum is 8 weeks, @ $625/week): ___________

Requested dates of benefits: Start Date: ___________ End Date: ___________

If you decide you no longer need the benefits during this time period or decide to go back to work in an IA-covered craft before this time period is up, **it is your responsibility to inform IATSE Local 478 of this change in circumstances immediately.** By signing this form, you acknowledge that, should you be deemed eligible for benefits, and should an audit disclose that you worked in an IA-covered craft while receiving Financial Assistance, the Union reserves the right to recoup the amount of benefits received after returning to work as an overpayment against you.

Signature: ____ Date: _______________________

Printed Name: ____