SHEET METAL INDUSTRY LABOR MANAGEMENT COOPERATION FUND
SMART/SMACNA Maternity Program Reimbursement Claim Form

Plan Claiming Reimbursement: FILLABLE ENTRY

Participant's Base Hourly Wage Rate: FILLABLE ENTRY

Number of Weeks Claimed During Pregnancy: FILLABLE ENTRY

Number of Weeks Claimed Post-Pregnancy: FILLABLE ENTRY

Weekly Wage Replacement Benefits Paid: FILLABLE ENTRY

Total Reimbursement Amount Requested: FILLABLE ENTRY

Plan Year in Which Leave Was Taken: FILLABLE ENTRY

Plan Certification of Eligibility

Individual for whom the Plan claims reimbursement is a participant on whose behalf contributions are made to the Plan requesting reimbursement, not a spouse or child of such a participant: **Y/N**

Individual for whom the Plan claims reimbursement was eligible for coverage under their local health plan on the date of disability: **Y/N**

The Plan has not received reimbursement from The Sheet Metal Industry Labor Management Cooperation Fund ("LMCF") for benefits paid to the Individual for whom the Plan claims reimbursement within the past 24 months: **Y/N**

Individual for whom the Plan claims reimbursement did not receive the benefit for a surrogate-related pregnancy, adoption of a child or foster care situation: **Y/N**

If the Plan is requesting reimbursement for benefits paid during the participant's pregnancy, the participant provided the Plan with written certification from a licensed medical practitioner stating the participant is unable to work due to limitations arising from pregnancy: (**see Instructions]* **Y/N/NA**

Reimbursement Request Submitted by: FILLABLE ENTRY

Title: FILLABLE ENTRY **Date of Submission:** FILLABLE ENTRY

Signature: FILLABLE ENTRY

Instructions

A Plan seeking reimbursement of sums expended on a maternity leave benefit **shall not** provide any participant's personal health information ("PHI") to the LMCF when applying for reimbursement. The participant that received the benefit **shall not** be identified directly (by name, SSN, member number) or indirectly (by DOB, address, employer, relationship, etc.). The Plan seeking reimbursement **shall not** provide the LMCF with specific medical documentation or any written or verbal descriptions of the participant's application for leave.

In granting reimbursement, the LMCF shall rely upon the certifications set forth in this reimbursement claim form. If, in its sole discretion, the LMCF requires additional documentation or disclosure of PHI to substantiate a claim or claims made by a Plan, it will request the information on a case-by-case basis with appropriate privacy procedures implemented to protect the participants, the Plan and the LMCF.

Plans are hereby notified that the LMCF is not obligated to approve any reimbursement request and there shall be no expectation otherwise. Nor shall a Plan have any beneficial or ownership right to LMCF assets on the basis of this SMART/SMACNA Maternity Program. Payment of reimbursement requests shall be made **only** upon approval by the Trust in its sole discretion.

MAKE CHECK PAYABLE TO: FILLABLE ENTRY

Please provide your Employer Identification Number (EIN): FILLABLE ENTRY

Please submit completed form to: EMAIL ADDRESS