

# CSEA Employee Benefit Fund

## Maternity Benefit Claim Form



This form must be completed and signed by the CSEA Employee Benefit Fund member. All required documentation must be attached.

### MAJOR PLAN FEATURES

- This benefit will pay \$200 upon the birth of a member's child to help cover the cost of maternity care.
- Multiple births receive multiple benefits.
- Members who give birth on maternity leave who would otherwise have been eligible for this benefit may still submit a claim.
- Members must be eligible for Fund benefits for a minimum of nine months prior to the birth of the child and must be benefits eligible on the child's date of birth.

### INSTRUCTIONS

- Submit this form with a copy of your child's birth certificate(s).
- All claims must be submitted no later than December 31st of the following calendar year.
- If enrollment for additional dependents is needed, an enrollment form can be obtained by calling 800-323-2732 or by visiting our website, [www.cseaebf.com](http://www.cseaebf.com)
- Submit for this benefit only if it has been negotiated for you under your collective bargaining agreement.

### TO BE COMPLETED BY MEMBER (PLEASE PRINT)

Member's Name \_\_\_\_\_ EBF ID# \_\_\_\_\_

Mailing Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Daytime Phone # \_\_\_\_\_ Email \_\_\_\_\_

New Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ M  F

Does this dependent have other dental coverage?  Yes  No

If yes, please indicate the name of the other plan \_\_\_\_\_ Effective Date \_\_\_\_\_

Member's Signature \_\_\_\_\_ Date \_\_\_\_\_

*Please allow up to 6 weeks for processing.*

### MAIL COMPLETED FORM TO

**CSEA Employee Benefit Fund**  
**PO Box 516**  
**Latham, NY 12110-0516**

***CLAIMS ARE NOT ACCEPTED BY FAX OR EMAIL***