This claim form should only be used if you are an eligible employee of one of the following units:

An Active Employee of:

Unified Court System
City of Long Beach
Long Beach Housing Authority
Smithtown Library
Town of Babylon
Town of Brookhaven
Town of Harrison
Town of Huntington
Town of Smithtown
Town of Southhold
Village of Lloyd Harbor
Village of Southampton

A Retired Employee of:

Unified Court System
Town of Brookhaven
Town of Southhold

BENEFIT SUMMARY

• 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.
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
- 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

CSEA Employee Benefit Fund 800-323-2732 www.cseaebf.com