CSEA Employee Benefit Fund
Maternity Benefit Claim Form

IMPORTANT - PLEASE READ THE FOLLOWING INFORMATION

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
City of New Rochelle
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 Southhampton

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

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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

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