RETURN BY MAIL OR FAX TO:
SCCEA
1363-24 Veterans Memorial
Highway Hauppauge, NY 11788
Phone: (631) 231-3983
Fax: (631) 231-3986

SUFFOLK COUNTY COURT EMPLOYEES ASSOCIATION, INC.
MATERNITY BENEFIT CLAIM FORM

MEMBER / EMPLOYEE'S INFORMATION [PLEASE PRINT OR TYPE]

Member/Employee's Name	Member's Date of Birth	Member's Social Security Number

Member's Street Address	City	State	ZIP Code	Telephone Number

Member's Work Location	Work Telephone Number

MATERNITY BENEFIT

Each eligible Member and/or retired Member is entitled to a benefit when their child is born, or if a child under the age of four is adopted, by the Member, through a licensed adoption agency. This $500.00 benefit is to assist in the cost of a live birth or adoption. If there are multiple births resulting from one pregnancy, the Member is entitled to multiple benefits.

To receive this benefit, you must file this form along with **a copy of the child's Birth Certificate** or adoption documents **within 12 months** of the date of birth or adoption. The Member's name must be listed on the Birth Certificate; if the Member's name is not listed, you must submit the **Alternative Proof Requirements** form.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR FUND, FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any insurance company, prepayment organization, hospital, physician, or The Board of Trustees of the Suffolk County Court Employees Association, Inc. Welfare Fund or its designated agent to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. A photocopy or fax of this authorization, when duly executed, shall serve in the same capacity as the original. I certify that the information submitted by me in support of this claim is true and correct.

AUTHORIZATION MUST BE SIGNED OR PAYMENT WILL NOT BE MADE.

Signed (Member): _____ **Date:** _____