HAWAII ELECTRICIANS
SUPPLEMENTARY UNEMPLOYMENT BENEFIT FUND

1935 HAU STREET, ROOM 300 ▪ HONOLULU, HAWAII 96819-5003 ▪ PHONE (808) 841-6169 ▪ FAX (808) 847-4596
Neighbor Islands Toll Free 1 (800) 622-3830

APPLICATION FOR SUB BENEFITS

Employee Name: ______________________________ **Social Security #:** ________________

Address: ______________________________ **Home Phone No.** ________________
Number and Street

______________________________ **Cell Phone No.** ________________
City State Zip Code

Employer (Current or Previous): ______________________________ **Hourly Pay Rate:** $ __________

THIS CLAIM IS FOR: (check applicable)

1. ☐ **TEMPORARY LAY OFF:** **Date last worked:** ________________

   OR

   ☐ **PERMANENT LAY OFF:** **Date last worked**: ________________

   - Submit a copy of State Unemployment Certificate of Entitlement and copy of benefit checks and payment record which is attached to each check.
   - I hereby certify that for TEMPORARY or PERMANENT lay off, I have registered with the Union's referral agent as provided by the Labor Agreement and have not refused any job offered which is covered by the Agreement.

2. ☐ **OCCUPATIONAL DISABILITY:** **Date Disabled**: ________________

   - Submit a copy of State Workers' Compensation checks or Notice of Entitlement or Hawaii Electricians Health & Welfare Supplemental Workers' Compensation checks.

3. ☐ **NON-OCCUPATIONAL DISABILITY:** **Date Disabled:** ________________

   - Submit a copy of Hawaii Electricians Health & Welfare Fund Weekly Disability Benefit checks or a completed doctor's note for sick leave.

4. ☐ **REDUCED WORK WEEK:** **For Week Ending:** ____________ **No. of Hrs. Worked** ______

   NO BENEFIT IS PAYABLE IF LACK OF WORK IS DUE TO LABOR DISPUTES BETWEEN THE LOCAL UNION 1186 IBEW AND SIGNATORY EMPLOYERS.

   ( ) You worked less than thirty two (32) hours in a week.

   ( ) You worked thirty-two (32) hours or less due to the reduction of the standard weekly work hours for the entire company and the reduction has been approved by the IBEW Local Union 1186.

   (Employer's verification is required)

   I hereby certify that the above hours reported in Item #4 above are due to lack of work and/or rain out.

   EMPLOYER SIGNATURE: ______________________________ **DATE:** ________________

5. ☐ **SEVERANCE:** **Date last worked:** ________________

   ( ) You left the jurisdiction of the Union (geographical or work) and no contributions on your behalf have been received by the Fund for at least six (6) months.

   ( ) Retired **Date Retired:** ________________

   ( ) Death **Date of Death:** ________________

EMPLOYEE SIGNATURE: ______________________________ **DATE:** ________________

FOR OFFICE USE ONLY

Start Date ____________ **End Date** ____________ **Benefit Amt** ____________ **Date Payable** ____________ **Code** ________