

**HAWAII ELECTRICIANS
SUPPLEMENTARY UNEMPLOYMENT BENEFIT FUND**

1935 HAU STREET, SUITE 450 ▪ HONOLULU, HAWAII 96819-5003 ▪ PHONE (808) 841-6169 ▪ FAX (808) 847-4596
Neighbor Islands Toll Free 1 (800) 622-3830
Email: benefits@heao.us.com

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 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 thirty two (32) hours or less 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 three (3) months.
 - () Retired _____ **Date Retired:** _____
 - () Death _____ **Date of Death:** _____

EMPLOYEE SIGNATURE: _____ **DATE:** _____

FOR OFFICE USE ONLY

Start Date _____ **End Date** _____ **Benefit Amt** _____ **Date Payable** _____ **Code** _____