



**United Food & Commercial Workers Unions
and Food Employers Benefit Fund**
6425 Katella Avenue • P.O. Box 6010, Cypress, CA 90630-0010
714-220-2297 • 562-408-2715

Application For Reinstatement Of Eligibility

Participant's Application *(Please Print)*

Participant's Last Name	First Name	MI	Social Security Number			
Mailing Address		City	State	Zip Code		
Home Phone Number ()	Email Address					
Employer's Name	Work Phone Number ()	Store Number	Union Local			

I was on paid vacation from _____ to _____.
Date of hire _____.
Anniversary month in which vacation hours were paid to you _____.

I was on Family Leave - Please submit a copy of Employers approval letter as verification.

I collected: Employees MUST submit proof of payment from the state or insurance carrier.
 State Disability Employees hired on or after March 1, 2004, may not use Workers Comp and
 Workers' Compensation Disability to extend coverage but should submit proof to prevent a break in service.
 for the period _____ to _____.

I failed to work the minimum monthly hours because I was scheduled less than my weekly guarantee in holiday week.
Date of holiday _____.

PLEASE SUBMIT PAYROLL STUBS AS VERIFICATION.

I did work the required straight-time hours during workweeks in the month(s) below:
Hours worked _____ Dates: from _____ to _____.
Hours worked _____ Dates: from _____ to _____.

PLEASE SUBMIT PAYROLL STUBS AS VERIFICATION.

NOTE: The standard workweek in the Industry is Monday through Sunday. Your monthly hours are credited to you as of the last Sunday of each month.

I returned to work on _____ following a maternity leave of absence.

ATTACH PAY STUBS FOR THE MONTH YOU RETURNED TO WORK AND THE FOLLOWING MONTH.

I returned to work on _____ following a military leave of absence.

IF DISCHARGED, ATTACH A COPY OF YOUR DD214.

IF SERVING IN THE MILITARY RESERVES, ATTACH COPIES OF YOUR MILITARY PAY VOUCHER SHOWING THE DATES YOU SERVED.

Participant's Signature _____ Date _____