



Supplemental & Benefits Trusts

PAID TIME OFF BENEFIT REQUEST

Last Name: _____ First Name: _____

Full Address: _____

SSN: _____ Date of Birth: _____

Email Address: _____ Phone Number: _____

HOURS REQUESTED: _____ (4 hours minimum, 16 hours maximum)

I understand that by completing and signing this form I am requesting a taxable income benefit. I also understand that Paid Time Off (PTO) benefits will not be paid to me unless I have submitted a completed Form W-9 and Beneficiary Designation Form to the Trust Administrative Office. I understand that any PTO benefit that I have accrued in a calendar year but have not applied to receive will be cashed out to me on February 15th of the following year so long as I have submitted a completed W-9 form and Beneficiary Designation form to the Trust Administrative Office by January 31st.

Signature: _____ Date: _____

Please Mail or Fax this form and supporting documents to:

Mail: Oregon Homecare Workers Trust, PO Box 6, Mukilteo, WA 98275

Fax: Oregon Homecare Workers Trust, 1-866-459-4623

Email: OHCWPTO@bsitpa.com Subject: OHCWT PTO

Phone: 844.507.7554 Option 3, then select Option 2

CLAIM: _____

The benefits of the Homecare Workers Supplemental and Benefits Trusts were negotiated by SEIU Local 503 homecare and personal support workers through their bargaining team.

P.O. BOX 6, MUKILTEO, WASHINGTON 98275

Trust Administration: 844-507-7554 fax: 866-459-4623 email: OHCWT@bsitpa.com

