



BENEFIT PLANS

VACATION PLAN

1007 EASTERN AVENUE, BALTIMORE, MD 21202-4345 • (410) 547-9111

CONVERTED OVERTIME WORKSHEET

NOT VALID WITHOUT APPLICATION FOR VACATION PAY

READ INSTRUCTIONS CAREFULLY BEFORE FILING

1. This application **MUST** be submitted simultaneously with your Application for Vacation Pay.
2. Only the original copy of the Company's certification should be submitted.
3. Complete the W-4 Employee's Withholding Allowance Certificate on the Application for Vacation Pay.
4. Specific payment instructions should be completed on the Application for Vacation Pay. You can Carry Over up to a maximum of 90 days of Converted Overtime and 90 days of Regular Vacation.

NOTE: Failure to complete all sections of this application, or include all applicable documentation may result in delayed processing of your claim.

NAME (Please Print)	Social Security Number	Birth Date
PERMANENT ADDRESS <small>(Street/PO Box)</small>	MAIL CHECK TO (If other than permanent address) <small>(Street/PO Box)</small>	
<small>(City, State & Zip)</small>	<small>(City, State & Zip)</small>	
Telephone Number	Cell Phone Number	

I understand that it is a violation of the MEBA Vacation Plan rules for me to work under the authority of my license (including night/relief work) during the period for which I am collecting vacation benefits, unless such work is performed under an Early Return Authorization. I further understand that the penalty for such violation will be loss of 6 months' employment credit toward my next vacation.

I hereby certify that the information contained herein is accurate. I understand that if I make omissions, false statements or collect money fraudulently from the MEBA Vacation Plan, I am subject to disciplinary action from the Union in accordance with the provisions of the Constitution, and loss of benefits from the MEBA Vacation Plan.

Signature of Applicant: _____ **Filing Date:** _____

At Branch Office of MEBA in: (City) _____ (State) _____

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TO BE FILLED OUT BY COMPANY REPRESENTATIVE:

PERIOD	VESSEL	TYPE	RATING	HOURLY RATE	HOURS	AMOUNT
TOTAL:						

Certified By: _____ Company Representative: _____ Name of Company: _____ Date: _____	Authenticating Seal
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VESSEL: NAME _____ **NUMBER** _____

TO BE COMPLETED BY OUTPORT REPRESENTATIVE				MEBA PLAN OFFICE USE ONLY			
PERIOD	AMOUNT	DAILY RATE	VACATION DAYS	DATE PAID	VACATION DAYS PAID	AMOUNT PAID	BALANCE DUE
TOTALS:							

Date Billed:	Amount Billed:	Processor:
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