L.I.U.N.A. LOCAL 1059 BENEFIT TRUST

CLAIM FORM FOR BEREAVEMENT BENEFIT

INSTRUCTIONS TO MEMBERS:

1. Complete Part A.
2. **HAVE YOUR EMPLOYER COMPLETE PART B.**
3. Either mail the completed form to: GLOBAL BENEFITS
88 ST. REGIS CRESCENT SOUTH
TORONTO, ON M3J 1Y8

   or fax the completed form to: 416-635-6464

PART A - TO BE COMPLETED BY MEMBER

MEMBER'S NAME: ____________________

DATE OF BIRTH: DAY (____) MONTH (__________) YEAR (________)

MEMBER'S SOCIAL INSURANCE NO. ________-________-________

MEMBERS ADDRESS: ____________________
APT. # STREET NAME

____
CITY POSTAL CODE

____
PHONE NUMBER

NAME OF DECEASED FAMILY MEMBER: ____________________

RELATIONSHIP TO MEMBER: ____________________

DATE OF DEATH: ______________ DATE OF FUNERAL: ______________

CITY/TOWN AND COUNTRY WHERE FUNERAL WAS HELD: ______________

NUMBERS OF DAYS EARNINGS WERE LOST: ______________

Maximum 3 working days (excluding weekends) between the date of death and the date of the funeral.

I hereby claim the bereavement benefit payable to me by the L.I.U.N.A. Local 1059 Benefit Trust and declare that the information given above is true and accurate. I understand that proof of death may be requested by the Administrator in order to process this claim.

____________________ ____________________
DATE **MEMBERS SIGNATURE**

NOTE: Bereavement Benefit is a wage replacement benefit and as such is a taxable income for which you will receive a T4A.

PART B — TO BE COMPLETED BY THE EMPLOYER

MEMBER'S NAME: ______________________ MEMBER'S S.I.N. ____-____-____

LAST DATE AT WORK BEFORE INTERRUPTION: ______________________

FIRST DATE AT WORK AFTER INTERRUPTION: ______________________

NUMBER OF DAYS WORK LOST BECAUSE OF INTERRUPTION: ____________

MEMBER'S BASIC HOURLY RATE: $______________________

NOTE: The maximum benefit payable shall be $150.00 a day for each day that the member is absent from work up to the maximum of three (3) consecutive days (excluding weekends) between the date of death and the date of the funeral.

I hereby declare that the above member suffered loss of earnings by interruption of the employment otherwise available to and normally performed by him, to the extent indicated above.

______________________	______________________
COMPANY NAME	SIGNATURE OF AUTHORIZED REPRESENTATIVE AND TITLE **PLEASE PRINT NAME BELOW**
PHONE # ______________________	______________________
	DATE: ______________________

An immediate family-member is:

- Your spouse
- You or your Spouse's parents
- You or Your Spouse's grandparents
- You or your Spouses child
- Your brother or sister

NOTE: Benefits are payable for days that you are absent from work ONLY and are not payable for periods of unemployment.

No payment shall be made for lost time following the date of the funeral unless the Member is required to travel for the purpose of attending the funeral.