LiUNA Local 1059 Benefit Trust

W.A. Health Inc. **149 Main St E, Hamilton ON L8N 1G4 • (289) 768-3621 • claims@wahealth.ca**

CLAIM FORM FOR BEREAVEMENT BENEFIT

INSTRUCTIONS TO MEMBERS:

1. Complete **Part "A"**
2. Have your EMPLOYER complete and sign **Part "B"**
3. Either mail or email the completed form to:

W.A. Health
149 Main St E
Hamilton, ON L8N 1G4
Telephone No. (289) 768-3621
Email: admin@wahealth.ca

PART A – TO BE COMPLETED BY MEMBER

Member's Name: _____

Date of Birth: _____|_____|_____
Day Month Year

Member's Social Insurance No. or Certificate No.: _____ _____ _____

Member's Address: _____ _____
Apt. # Street Name

_____ Postal Code: _____
City/Province

Name of Deceased Family Member: _____

Relationship to Member: _____

Date of Death: _____|_____|_____
Day Month Year

Date of Funeral: _____|_____|_____
Day Month Year

City/Town and Country where Funeral was held: _____

Number of Days Earnings were Lost: _____

MAXIMUM 3 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 LIUNA Local 1059 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 the claim.

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

_____ _____|_____|_____
Member's Signature Date

PART B – TO BE COMPLETED BY EMPLOYER

Member's Name: _____

Member's Social Insurance No. or Certificate No.: _____ _____ _____

Last Date at Work before interruption: _____|_____|_____
Day Month Year

First Date at Work after Interruption: _____|_____|_____
Day Month Year

Number of days work lost because of interruption: _____

Additional Information, if needed:

_____

_____

NOTE: **The Maximum Benefit payable shall be $150 a day for each day that the member is absent from work up to maximum of 3 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/her, to the extent indicated.

_____ _____
Company Name Signature of Authorized Representative and Title

_____
Print Name

_____ _____
Telephone Number Date

An immediate family is:
Your spouse
Your or your spouse's parents
Your or your spouse's grandparents
Your or your spouse's 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.

Not 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.