



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

City/Province | Postal Code

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: _____

Member's usual basic hourly rate: \$_____

Additional Information, if needed:

NOTE: The Maximum Benefit payable shall be \$175 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.