

CEMENT MASON'S LOCAL 598 WELFARE PLAN

Bereavement Benefit - Statement of Claim

MEMBER INFORMATION

- The maximum benefit payable is \$150.00 per day, for up to 3 days, for each day that the Member is absent from work between the date of death of the family member and the date of the funeral.
- A Death Certificate or a Funeral Director's Statement must be attached to this claim form.
- 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.
- Bereavement pay for lost time on Saturday or Sunday will only be paid if the member was scheduled to work on such day and this requirement is verified by the member's employer.
- Benefits are payable for days that you are absent from work ONLY and are not payable for periods during which you are unemployed.
- This is a wage replacement benefit considered to be taxable income for which you will receive a T4A.

SECTION 1 - TO BE COMPLETED BY THE MEMBER <i>(please print)</i>				
MEMBER'S NAME (Last)			(First)	
ADDRESS (Number, Street, City, Province)			POSTAL CODE	
PHONE NUMBER ()	DATE OF BIRTH Day Month Year		CERTIFICATE NUMBER	LOCAL UNION 598
NAME OF DECEASED FAMILY MEMBER (Last)			(First)	
RELATIONSHIP OF DECEASED TO MEMBER				
DATE OF DEATH		DATE OF FUNERAL		
CITY OR TOWN WHERE FUNERAL WAS HELD		NUMBER OF DAYS LOST EARNINGS BEING CLAIMED: <i>(excludes weekend days)</i> <input type="checkbox"/> 1 DAY <input type="checkbox"/> 2 DAYS <input type="checkbox"/> 3 DAYS		
<p>I hereby certify that the above statements are true, accurate and complete to the best of my knowledge and belief. I understand that the Plan Administrator will use the information provided by me on this claim form strictly to process my claim. I hereby authorize the use of my Social Insurance Number for tax reporting and the administration of my benefits. I hereby authorize the Plan Administrator to evaluate or investigate my claim, and release my personal information to qualified third parties solely for the purpose of conducting such evaluations or investigations, and only to the extent required for such purposes. I hereby authorize my employer to release relevant information to the Plan Administrator solely for the purpose of processing this claim.</p>				
Member's Signature _____			Date _____	

SECTION 2 - TO BE COMPLETED BY THE EMPLOYER <i>(please print)</i>			
1. Last date at work before interruption?	Day	Month	Year
2. First date at work after interruption?	Day	Month	Year
3. Number of work days lost because of interruption?			
<p>I hereby confirm that the above noted Member suffered a loss of employment earnings otherwise available to and normally performed by the Member, to the extent indicated on this form.</p>			
Name of Company: _____	Telephone Number: _____		
Signed by: _____	Title: _____		
Date: _____			

ONCE COMPLETED, PLEASE ATTACH A COPY OF THE DEATH CERTIFICATE OR FUNERAL DIRECTOR'S STATEMENT AND FORWARD TO THE OFFICE OF THE ADMINISTRATOR:

Manion, Wilkins & Associates Ltd
626 - 21 Four Seasons Place
Etobicoke, ON
M9B 0A6
416-234-3511
1-866-532-8999 (Toll Free)