DRYWALL, ACOUSTIC, LATHING AND INSULATION LOCAL 675 LIFE & HEALTH TRUST FUND

Bereavement Benefit - Statement of Claim

MEMBER INFORMATION

- The maximum benefit payable is $200.00 per death, per day, for up to 3 days, for each day that the Member is absent from work betwe 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.
- Benefits are payable for days that you are absent from work ONLY and are not payable for periods of unemployment.
- 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 ***(please print)***

MEMBER'S NAME (Last)	(First)

ADDRESS (Number, Street, City, Province)	POSTAL CODE

PHONE NUMBER	DATE OF BIRTH			CERTIFICATE NUMBER	LOCAL UNION
( )	Day	Month	Year		DALI L-675

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: (excludes weekend days) ☐ 1 DAY ☐ 2 DAYS ☐ 3 DAYS

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.

Member's Signature _____ Date _____

SECTION 2 - TO BE COMPLETED BY THE EMPLOYER ***(please print)***

	Day	Month	Year
1. Last date at work before interruption?			
2. First date at work after interruption?			

3. Number of work days lost because of interruption? _____

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.

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 416-234-2071 (Fax)
1-866-532-8999 (Toll Free) claims@manionwilkins.com (Email)