DRYWALL, ACOUSTIC, LATHING AND INSULATION LOCAL 675 BENEFITS

Bereavement Benefit – Statement of Claim

- Up to $200.00 per day is payable for each day that you, the eligible Member, is absent from work from the date of death and the date of the funeral, up to a maximum of 3 days.
- Benefits are not payable for Saturdays or Sundays unless you were scheduled to work on one or both of those days. Benefits are not payable when you are not actively at work for any reason (e.g. unemployed). No payment shall be made for lost time following the date of the funeral unless you travelled more than 400 kilometers or 4 hours one way to attend the funeral.
- Bereavement Benefits paid are a wage replacement benefit and as such the payment is taxable income for which you will receive a T4A.
- A copies of the deceased's Death Certificate or Funeral Director's Statement must be attached to this claim form.

SECTION 1 – TO BE COMPLETED BY THE MEMBER *(please print)*

MEMBER INFORMATION

LAST NAME		FIRST NAME	
ADDRESS	CITY	PROVINCE	POSTAL CODE
PHONE NUMBER:	DATE OF BIRTH (DD/MM/YYYY)	CERTIFICATE NUMBER: U	LOCAL UNION

NAME OF DECEASED FAMILY MEMBER

LAST NAME	FIRST NAME

RELATIONSHIP OF DECEASED TO MEMBER

DATE OF DEATH (DD/MM/YYYY)	DATE OF FUNERAL (DD/MM/YYYY)	DISTANCE TRAVELLED TO FUNERAL __________KMS or FLIGHT (attach itinerary)

LOCATION OF THE FUNERAL CITY, PROVINCE/STATE, COUNTRY	NUMBER OF DAYS LOST EARNING BEING CLAIMED ☐ 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 Manion, the Plan Administrator, will use the information provided by me on this claim form strictly to evaluate and process my claim. I hereby authorize my employer to release relevant information to Manion solely for purposes of this claim.

_________________________________ Member's Signature

_________________________________ Date

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

Last date at work before leave _________________________ (DD/MM/YYYY)   Date returned to work after leave ____________________________ (DD/MM/YYYY)

Number of work days lost due to leave____________________   Scheduled work days lost included ☐ Saturday ☐ Sunday

Member's hourly rate of pay $_______________

I, _____________________________ (print name), hereby declare that the above Member suffered a loss of earnings by interruption of employment otherwise available to this Member.

Company ______________________________________   Title of Signatory____

Signature ______________________________________   Phone No. & E-mail _____________________________________

Date____ (DD/MM/YYYY)

COMPLETE AND ATTACH A COPY OF PROOF OF DEATH AND PROOF OF TRAVEL, AS REQUIRED AND FORWARD TO:

Manion Wilkins & Associates Ltd.
626 – 21 Four Seasons Place
Etobicoke, ON
M9B 0A5

Email: claims@manionwilkins.com
Fax: 416-234-2071
Phone: 416-234-3511
Toll Free: 1-866-532-8999