I.B.E.W. L.U. 2085 Health & Welfare Trust Fund

I.B.E.W. L.U. 2085
HEALTH & WELFARE
BEREAVEMENT BENEFIT
CLAIM FORM

MEMBER NAME: _____

MEMBER SIN#: _____

MEMBER ADDRESS: _____
STREET

_____
CITY PROVINCE POSTAL CODE

RELATIONSHIP TO DECEASED: _____

*VERIFICATION ATTACHED: _____

The benefit payable is $350 for 1 day bereavement. This benefit is taxable. As such a tax receipt will be issued to you by the Plan Administrator.

To be eligible for this benefit, the member must have a minimum of two (2) Consecutive Years positive membership in the I.B.E.W. L.U. 2085.

I authorize the use of my Social Insurance number (SIN) for claims identification purposes, and, as required by law, for income tax reporting. A copy of this authorization shall be valid as the original.

Member Signature: _____ Date: _____

Union Authorization: _____

*Verification of death/relationship includes Obituary from Local Newspaper, Physician's Statement or Funeral Notification/Memorial Card.

Mail the completed form and obituary (or other deceased verification)
to the Administrator for processing at
Coughlin & Associates Ltd.
100 – 175 Hargrave Street
Winnipeg, MB R3C 3R8