Carpentry Workers' Benefit Plan of B.C.

#215 – 3480 Gilmore Way, Burnaby B.C. V5G 4Y1 Tel (604)438-2434 Fax (604) 438-5348
Toll free 1-877-411-2806 Online at www.cwbp.ca

BEREAVEMENT LEAVE CLAIM FORM

Benefits are payable to any member covered under the Employer paid regular plan and employed at the time of leave. The Plan will compensate up to a maximum of five (5) days leave from work at 75% of the Industrial Carpenters' Rate.

Name: _____ **Member Number:** _____

Address: _____

Postal Code: _____ Phone Number (_____) _____

☐ *Check box if this is a new address*.

Bereavement leave is available in the event of the death of a member's immediate family.

Relationship of deceased to member: *(proof of death is required: include a copy of the obituary or death certificate with the claim)*

- ❒ Spouse (married or common-law)
- ❒ Father
- ❒ Father-in-law
- ❒ Brother
- ❒ Grandfather
- ❒ Grandchild
- ❒ Child
- ❒ Mother
- ❒ Mother-in-law
- ❒ Sister
- ❒ Grandmother

Name of deceased: _____ Date of death: _____

You must have been working at the time of bereavement leave. Please complete the details of your employment and have your supervisor sign below.

Employer's name: _____ Phone Number: (____)_____

Date/s of absence**:** ___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___
mm/dd/yr *mm/dd/yr* *mm/dd/yr* *mm/dd/yr* *mm/dd/yr*

_____ _____ _____
Name of supervisor Signature of supervisor Date signed

I certify that all the information on this claim form is correct. I consent to the Carpentry Workers' Benefit Plan ("the Plan") using this personal information to adjudicate my claim. I understand that the Plan may contact the employer I have listed on this claim form to verify my employment.

_____ _____
Signature of member **Date signed**

Please note: Bereavement Leave is considered taxable income; you will receive a T4A slip for "other income" which must be included as income on your tax return for the calendar year it is received.

Please return the completed form and the proof of death to the Plan office at the above address.

OFFICE USE ONLY

Employer Paid Full Plan Y ____ N ____

Employer Paid MSP Plus Y ____ N ____

Adjudicator _____ **Date processed** _____