CMAW Benefit Plan

#160 – 4400 Dominion Avenue, Burnaby, BC V5G 4G3
phone (604) 299-7482 toll free 1-800-663-1356 fax (604) 299-8136

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 CMAW 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.

PLAN OFFICE USE ONLY

Employer Paid Full Plan **Y** ____ **N** ____ **Adjudicator** _____

Employer Paid MSP Plus **Y** ____ **N** ____ **Date processed** _____