SHOREWORKERS' BENEFIT FUND

LOSS OF LIFE BENEFIT

Amount of Benefit

a) **On the loss of life, due to any cause, of a qualified member (a member who has accumulated 1,000 hours of work**), a Loss of Life Benefit shall be payable to the member's beneficiaries:

i. Two thousand dollars ($2,000) where the claimant is the spouse of the deceased or a dependent child, plus one thousand dollars ($1,000) for each dependent child.

b) one thousand five hundred dollars ($1,500) where:

i. a member has reached four hundred (400) hours of work but less than one thousand (1,000) hours of work.

ii. or, the claimant is not a dependent but who is a relative or a named beneficiary

iii. or, to a person who assumes responsibility for the funeral and related expenses

Beneficiaries

The Shoreworkers' Benefit Fund shall have the exclusive right to decide the status of a claimant or claimants as a beneficiary.

Definition of beneficiary - guidelines

a) Where there is a legal marriage, the spouse shall be considered a beneficiary

b) Common-law relationship- the partner shall be considered a beneficiary provided, however, the common-law relationship has endured for 1 year

c) Minor children left without parents- loss of life benefit shall be placed in trust to the account of minor children payable upon the child attaining 18 years of age.

d) The estate of a deceased member shall not be considered a beneficiary. A beneficiary may be named if members so wish, by completing a Beneficiary Card.

e) Beneficiaries have the option of placing all or part of their loss of life Benefit in a trust fund for their minor children.

Dependents

a) A dependent child eighteen (18) years and under.
b) A dependent child 25 years of age and under if he or she is in full time attendance as a student at an accredited school, college or university.
c) A son or daughter twenty-one (21) years of age or older who is incapable of selfsupport and is wholly dependent upon the member for support.

The above is a general description, If you need help or more information:

SHOREWORKERS' BENEFIT FUND: 604 519-3634
First Floor - 326 12th Street, New Westminster, BC V3M 4H6

UFAWU-Unifor New Westminster: 604 519 3630
UFAWU-Unifor Prince Rupert: 250 624 6048 or 1-888 624 6625

SHOREWORKERS' BENEFIT FUND

1ST FLR, 326–12TH STREET, NEW WESTMINSTER, B.C. V3M 4H6 • TEL: 604-519-3644 • FAX: 604-524-6944

LOSS OF LIFE

NAME OF DECEASED _____

SOCIAL INSURANCE NUMBER _____

RESIDENCE OF DECEASED _____

_____ **POSTAL CODE** _____

DATE OF BIRTH _____ **PLACE OF BIRTH** _____

EMPLOYED AT (NAME OF CANNERY OR PLANT) _____

JOB _____

DATE LAST WORKED _____

PROOF OF DEATH

• PLEASE SUBMIT COPY OF DEATH CERTIFICATE •

DATE OF DEATH _____ **PLACE OF DEATH** _____

CAUSE OF DEATH (NAME OF ATTENDING PHYSICIAN OR CORONER) _____

_____

NAME OF CLAIMANT _____

RELATIONSHIP TO DECEASED _____

ADDRESS OF CLAIMANT _____

_____ **POSTAL CODE** _____

PHONE: _____

DATE: _____ 20 _____ **SIGNATURE:** _____

(Please be sure to complete and sign the other side of this form)

TO BE COMPLETED AND SIGNED IF THE CLAIM IS BEING MADE BY THE SPOUSE.

I hereby declare that I am the spouse of at the time of death and have been since _____

_____ **and I am claiming Loss of Life benefits as his/her beneficiary.**

All information is true and complete. I consent to the disclosure of this personal information to SWBF, to other insurance companies, and to other authorized third parties for the purpose of administering my plan, assessing and providing benefit coverage, or when required by law.

DATE _____ CLAIMANT'S SIGNATURE _____

TO BE COMPLETED AND SIGNED IF THE CLAIM IS BEING MADE FOR DEPENDENT CHILDREN, PLEASE INCLUDE PHOTOCOPIES OF BIRTH CERTIFICATES AND OR OTHER VERIFICATION OF BIRTHDATES.

THE CHILDREN OF THE DECEASED WHO ARE BETWEEN 0-18 YEARS OF AGE AND UNDER, OR WHO ARE DEPENDENT ON THE DECEASED AND BETWEEN 19 TO 25 YEARS OF AGE ARE:

NAME	ADDRESS	DATE OF BIRTH

All information is true and complete. I consent to the disclosure of this personal information to SWBF to other insurance companies, and to other authorized third parties for the purpose of administering my plan, assessing and providing benefit coverage, or when required by law.

DATE _____ CLAIMANT'S SIGNATURE _____

TO BE COMPLETED BY A WITNESS

I hereby certify that the above claimant _____

who is personally known to me appeared before me on the _____ day of _____

_____ and stated that the above statements are true and correct and that all material facts have been stated herein.

NAME OF WITNESS (PLEASE PRINT) _____

ADDRESS _____ **PHONE:** _____

DATE: _____ 20 _____ **SIGNATURE OF WITNESS** _____