SHOREWORKER BENEFIT FUND:

FUNERAL BENEFIT

GENERAL INFORMATION:

A Funeral Benefit shall be payable upon the death of a shoreworker who has maintained Honourary Membership in the United Fishermen and Allied Workers' Union-Unifor

Payment of Benefit

a) the Funeral Benefit shall be payable on behalf of a deceased Honourary member to:

i. a person who assumes financial responsibility for the funeral and related expenses, or

ii. where there is no claim by a person assuming financial responsibility, the benefit shall be payable to the spouse of the deceased,

b) The estate of a deceased member shall not be considered eligible for payment of this benefit.

Amount of Benefit

The amount of the Funeral Benefit shall be one thousand dollars ($1,000).

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

CLAIM FOR FUNERAL BENEFIT

APPROVED:	
CHEQUE NO:	

DATE: _____

NAME OF DECEASED _____

LAST ADDRESS _____

SOCIAL INSURANCE # _____ DATE OF BIRTH (M/D/Y) _____

PLACE OF BIRTH (TOWN & COUNTRY) _____

COMPANY LAST EMPLOYED BY: _____

_____ DATE OF RETIREMENT (M/D/Y): _____

DATE OF DEATH (M/D/Y): _____ PLACE OF DEATH: _____

CAUSE OF DEATH: (Description in doctor's or coroner's report if available — if not, name and address of attending physician or coroner.) _____

_____

_____

_____

NAME OF CLAIMANT _____

RELATION OF CLAIMANT TO DECEASED: _____

ADDRESS OF CLAIMANT _____

_____ POSTAL CODE: _____

PHONE: _____

PLEASE SUBMIT THE FOLLOWING WITH THIS FORM:

— a certified copy of the Death Certificate

— all receipts pertaining to the funeral.

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 SIGNATURE OF MEMBER