Teamsters Local Union No. 155 Health Benefits Plan

c/o Convyta Partners

Phone: 1-855-832-6155 | Fax: 604-433-8894 | teamsters155@convyta.com

BEREAVEMENT LEAVE CLAIM FORM

Benefits are payable to any member covered on an employer-paid Full Plan (not on self-pay) who is available for work during the time of the bereavement leave. The Plan will compensate up to a maximum of five (5) days leave from work based on the Local 155 $425.00 loss time wages formula.

Member Name	**Member Number**
Address (street number and name)	**Phone Number**

City	**Province**	**Postal Code**

☐ *Check box if this is a new address*

Bereavement leave is available in the event of the death of a member's immediate family. **Proof of death is required; please include a copy of the obituary or death certificate with the claim.** You must have been available for work during bereavement leave.

Name of Deceased	**Date of Death**

Relationship of Deceased to Member	☐ Spouse (married or common-law)	☐ Child
	☐ Father	☐ Mother
	☐ Father-in-law	☐ Mother-in-law
	☐ Brother	☐ Sister
	☐ Grandfather	☐ Grandmother

Signature of Local 155 Signing Officer	**Date Signed**

I certify that all the information on this claim form is correct. I consent to the Teamsters Local Union No. 155 Health Benefits 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 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, or to the Union.

FOR OFFICE USE ONLY

Compensation rate:	
Number of straight time equivalent hours pay missed:	
Cheque total:	
Adjudicator:	**Date processed:**