IUOE Local 793

Bereavement Claim

Pension and Benefits
Administered by

A Introduction

The Bereavement Benefit applies only to you, the Plan Member, if you were covered by the plan at the time of the event and only if you (and not your Dependants) had a loss of earnings, i.e. you were working and were not on Pay Direct at the time of the death. The maximum benefit payable is $175 a day for each day of absence from work, up to a maximum of five (5) consecutive working days, excluding weekends, following the date of the death.

You can claim the Bereavement Benefit only for the deaths of:

- Your Spouse
- Your or your Spouse's natural grandparent or great-grandparent
- Your or Your Spouse's parent including stepmother or stepfather
- Your or your Spouse's child including natural child, stepchild, legally adopted child, foster child, son-in-law, or daughter-in-law
- Your brother or your sister including a stepbrother, stepsister, brother-in-law, or sister-in-law
- Your or your Spouse's grandchild or great-grandchild

You can also include in this claim days lost due to a Celebration of Life ceremony held later to honour the deceased if you had not taken the full five days before.

Please request, fill in, and return an updated Personal Information File (PIF) to notify OEBAC of <u>any changes</u> in information about: **(a)** you, the Plan Member; **(b)** your dependants; **(c)** any other health care plan that you or your dependants may have; **(d)** your beneficiaries; **(e)** your bank accounts; or **(f)** the individuals authorized to inquire about your benefits. By doing this on time, you will facilitate faster processing of your claims and reduce the chances of claim rejection.

B To be completed by Plan Member

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ABCDEFGH

Full Name		From your OEBAC Benefits Card Group #: ☐ 793 ☐ 793X Certificate #: Or, from your IUOE Local 793 Card Registration #:
Phone #	Email	

Please complete the following information about the deceased person:

Deceased Person's Full Name		Relationship to Plan Member
Date of Death (yyyy-mm-dd)	Date of Funeral (yyyy-mm-dd)	City and Province of the Funeral

By signing below,

- I solemnly declare that the information provided in this form is accurate to the best of my knowledge.
- I authorize IUOE Local 793, OEBAC, and any of its service providers to use and disclose the provided information and any other information collected about me, my Dependants, or my Beneficiaries to process my benefits, to obtain advice, and to manage the Health and Welfare, Group Legal, and Pension Benefits Plans.

Name of Plan Member	Signature of Plan Member	Date (yyyy-mm-dd)

C To be completed by Employer

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Company Name	Name of Authorized Representative
Phone # of Authorized Representative	**Email of Authorized Representative**

Last full date worked before death of family member (yyyy-mm-dd)	First full day at work after death of family member (yyyy-mm-dd)	Number of full days of work missed

I hereby declare that the above-named Plan Member suffered loss of earnings by interruption of the employment while otherwise available and normally performed by the Plan Member, to the extent indicated above.

Name of Authorized Representative	Signature of Authorized Representative	Date Signed (yyyy-mm-dd)

Staple this form and all the attachments and mail them to

OEBAC
2201 Speers Rd., Unit 1
Oakville, ON L6L 2X9

or

Scan this form and the requested attachments (both sides if required) and email to
info@oebac.org