



CONSTRUCTION MAINTENANCE AND ALLIED WORKERS CANADA

UNINSURED LIFE BENEFIT CLAIM FORM

The Union provides a life benefit of \$5,000.00 should any CMAW member pass away prior to becoming eligible for coverage under the CMAW Benefit Plan and provided they have completed their Union membership card, and Local Union Dues are in good standing. This benefit will be paid to their Estate from the Member Assistance Fund.

MAILING ADDRESS

Mail: CMAW Canada
211-3823 Henning Drive
Vancouver, BC V5C 6P3

Fax: 604-437-1110

INSTRUCTIONS

Please print clearly and be sure all sections are complete to avoid delays in processing the claim.

The completed form may be mailed or faxed.

1. APPLICANT INFORMATION

Name of Legal Representative or Applicant:

_____ (First Name)

_____ (Last Name)

Mailing Address: _____

Telephone Number: _____

Email: _____

2. DECEASED INFORMATION

Name of Deceased Member:

_____ (First Name)

_____ (Last Name)

Mailing Address: _____

Member Local: _____

Join Date (if known): _____

(MMM/DD/YYYY)

Date of Death: _____

(MMM/DD/YYYY)

Place of Death: _____

**Please attach a photocopy of the death certificate.*

3. AUTHORIZATION BY APPLICANT

I hereby authorize the adjudicator or their agent, and any other person, to release and exchange with CMAW, the group plan administrator or their representatives, and/or agents, any and all such information necessary for the purposes of confirming the accuracy and validity of this claim and to administer this claim. I understand that my refusal or withdrawal of consent may delay claims adjudication or result in denial of this claim. I declare that the information provided in this statement and any statements provided in any personal or telephone interview relating to this claim are/will be true, complete, and accurate. This authorization shall remain valid for the duration of the claim unless revoked in writing by me. Any copy of this authorization should be valid as the original.

Claimant Signature: _____

Date: _____

(MMM/DD/YYYY)

TO BE COMPLETED BY CMAW – DO NOT COMPLETE

Authorized by: _____

(Initials)

Signature: _____

Date: _____

(MMM/DD/YYYY)