UFCW Northern California & Drug Employers Health and Welfare Trust Fund
LIFE & ACCIDENTAL DEATH CLAIM FORM

UFCW TRUST
Working For Your Benefit

EMPLOYEE INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Social Security #: _____

DECEASED INFORMATION (SELECT EMPLOYEE OR DEPENDENT AND COMPLETE THE RELEVANT SECTION)

☐ Employee Deceased

Date of Death: _____ (MM/DD/YYYY) Date of Birth: _____ (MM/DD/YYYY)

Last Date Worked: _____ (MM/DD/YYYY) Name of Last Employer: _____

☐ Dependent Deceased

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Death: _____ (MM/DD/YYYY) Date of Birth: _____ (MM/DD/YYYY)

Relation to Employee:

- ☐ Spouse *[Required Documentation: Copy of Marriage Certificate]*
- ☐ Domestic Partner *[Required Documentation: RDP Certificate]*
- ☐ Child *[Required Documentation: Copy of Birth Certificate]*
- ☐ Other: _____

CLAIMANT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Social Security #: _____ Date of Birth: _____ (MM/DD/YYYY) Phone #: _____

Address: _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP CODE)

Under penalty of perjury, I hereby certify that the above information was correct upon the deceased's death.

X _____ (CLAIMANT'S SIGNATURE) _____ (MM/DD/YYYY)

Please Read: No benefits will be paid if the claim is received by the Trust Fund Office more than one year after the Member or Dependent's death.

REQUIRED ATTACHMENTS FOR ALL CLAIMS:

CERTIFIED COPY OF THE DEATH CERTIFICATE

PLEASE COMPLETE AND RETURN TO: UFCW & EMPLOYERS TRUST, P.O. BOX 4100, CONCORD, CA 94524-4100