BEREAVEMENT LEAVE CLAIM FORM
FOR REIMBURSEMENT FROM FRINGE RESERVE PURSUANT TO THE PROVISIONS
OF THE APPLICABLE COLLECTIVE BARGAINING AGREEMENT

MILL CABINET INDUSTRY EMPLOYEES BENEFIT
TRUST FUND FOR NORTHERN CALIFORNIA
P.O. BOX 2280
OAKLAND, CA 94621
TELEPHONE (888) 547-2054 OR (510) 633-0333

Name of Employee: _____ SS or I.D.#: _____

Address: _____

Classification: _____ Wage Scale per Hour: $_____
(Journeyman, Apprentice, Trainee, etc.) *(Not to exceed contractual wage.)*

Employee Signature: _____ Date: _____

Name of Deceased:_____ Date of Funeral or Service:_____

Relationship to Employee: _____
(Parent, Parent-in-law, Grandparent, Legal Guardian, Spouse, Sibling, Child, etc.)

NOTE: Attach a copy of the newspaper death notice, announcement, etc.

Amount of gross wages paid by employer at regular straight time for those days within the employee's regularly scheduled work week.

_____ Regular Work Hours at $ _____ per hour
Total amount due employer: $ _____

Note: Reimbursement is limited to 3 workdays.

Firm Name: _____ Employer No.: _____

Address: _____

Employer Signature: _____ Date: _____

Fund Office Use Only:

EMP ACC Approval: _____ Check Request: _____ Check Mailed: _____