



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

**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: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
MM/DD/YYYY MM/DD/YYYY  
Last Date Worked: \_\_\_\_\_ Name of Last Employer: \_\_\_\_\_  
MM/DD/YYYY

Dependent Deceased

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Date of Death: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
MM/DD/YYYY 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: \_\_\_\_\_ Phone #: \_\_\_\_\_  
MM/DD/YYYY  
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**