

UNITED FISHERMEN'S BENEFIT FUND

SHIPWRECK BENEFIT

This is a general description of the Benefit. For more information, please contact: UFBF Director

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Payable for loss of personal belongings due to shipwreck or fire

Maximum during the season. **\$700**

Maximum during the off-season. **\$250**

Type of Benefit

The Fund provides a payment to compensate a member for the irretrievable loss or serious damage to personal belongings caused by fire or water as a result of an accident occurring to a vessel.

“Personal belongings” means all items of personal effects normally carried on board a fishing or packing vessel for personal use or comfort, including tools but not including money or securities or grub or articles of boat equipment.

During the fishing season – \$700.

During the fishing season for the purpose of collecting Shipwreck Benefits means up to a maximum of one month prior to the opening of the fishing season and up to a maximum of one month after the end of the fishing season.

The above is a general description of the Benefit. For more information, please contact:

United Fishermen's Benefit Fund: 778 645 0578

250 624 6048 or 604 519 3644

UFAWU-Unifor: #4 - 830 14th Ave Campbell River, B.C. V9W 4H4

NAME AND ADDRESS OF WITNESSES TO ACCIDENT, IF ANY:

WERE ANY ITEMS OF YOUR PERSONAL PROPERTY ABOARD THE BOAT UNDAMAGED OR SAVED?

YES NO

WERE ANY ITEMS OF PERSONAL PROPERTY SALVAGED AND CLEANED OR REPAIRED?

YES NO

WHAT IS YOUR OWN ESTIMATE OF THE VALUE OF THE PERSONAL BELONGINGS YOU LOST AS A RESULT OF THE ACCIDENT? (NOTE: DO YOU INCLUDE IN THIS ESTIMATE ANY CASH, FOOD, CROCKERY, BOAT EQUIPMENT OR NETS — YOU MAY INCLUDE IN YOUR ESTIMATE COSTS FOR CLEANING OR REPAIRING OR DAMAGED PERSONAL BELONGINGS \$_____

I HEREBY MAKE CLAIM TO THE BOARD OF TRUSTEES OF THE UNITED FISHERMEN'S BENEFIT FUND FOR \$_____ AS COMPENSATION IN RESPECT OF PERSONAL BELONGINGS IN ACCORDANCE WITH THE RULES OF THE FUND AND CERTIFY THE ABOVE INFORMATION IS TRUE AND CORRECT. I AGREE THAT THE DECISION OF THE TRUSTEES UPON THIS CLAIM WILL BE ACCEPTED BY ME AS FINAL.

DATE: _____ SIGNATURE OF CLAIMANT: _____

I HEREBY CERTIFY THAT THE ABOVE CLAIMANT _____

WHO IS PERSONALLY KNOWN TO ME, APPEARED BEFORE ME ON THE _____ DAY OF _____, 20____ AND STATED THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT, AND THAT ALL MATERIAL FACTS HAVE BEEN STATED HEREIN.

SIGNATURE OF WITNESS: _____

ADDRESS: _____

RECOMMENDATION OF LOCAL: _____

All information is true and complete. I consent to the disclosure of this personal information to UFBF, to other insurance companies, and to other authorized third parties for the purpose of administering my plan, assessing, and providing benefit coverage, or when required by law.

DATE

SIGNATURE OF MEMBER

All claims should be mailed or delivered to:

Benefit Fund Director, UFAWU-UNIFOR #4 -830 14th Ave Campbell River, V9W 4H4