Choggiung Limited
P.O. Box 330
Dillingham, Alaska 99576
Phone: 907-842-5218
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Bereavement Benefit Request

It is the policy of Choggiung Limited to provide a payment of up to $1000 in connection with the death of certain shareholders, descendants of shareholder, or spouses of shareholders to assist with funeral expenses. Requests will be processed as soon as possible but may take up to 5 business days for payment to be provided.

Benefit eligibility requirements:

- On the date of death, the deceased must be a shareholder of Choggiung who is a Native or a descendant of a Native (as those terms are used in the Alaska Native Claims Settlement Act), a descendant of such a shareholder, or the spouse of such a shareholder. "Spouse" means a person who is legally married to such a shareholder at the time of death. Descendant means a direct lineal descendant child, grandchild, great grandchild, etc.
- The person applying for the benefit must be one of the following, in order:
  (When necessary, verification documents will be requested in order to process.)
  1. Executor/Power of Attorney
  2. Spouse
  3. Child
  4. Parent
  5. Sibling

Payment is subject to the following:

- The request for payment of funeral expenses must be made within 60 days after the death of a shareholder or spouse.
- The payment will be paid directly to a business or person for funeral related expenses.
- Choggiung reserves the right to question the reasonableness of any payment request and reserves the right to make full or partial payments, or to deny any payments in its sole discretion.

Name of deceased: ____

Birth Date: ________________________________ **Last 4 of SSN:** ____________________________

Date of death: ____

Payable to: ____

Mailing Address: ____

Payable for: ____ **Phone:** ________________________

** **

By my signature below, I certify that the funds received are to help pay for funeral related expenses.

Printed Name of Applicant_______________________ **Relationship to Deceased:** _________________

Signature: ______________________________________ **Date:**_________________________________

Last 4 of SSN: _____________________________ **Phone:** ______________________________________

Mailing Address: ____

FOR STAFF USE ONLY:

Benefit Paid: $________________ Date:__________________ Paid to: ___________________________

Staff Signature: ______________________________________ Date:______________________________