



Choggiung Limited
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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, parent of a 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 parent of a shareholder, or the spouse of a shareholder. "Descendant" means a direct lineal descendant child, grandchild, great grandchild, etc. "Parent" means biological parent, adoptive parent, step-parent, or legal guardian. "Spouse" means a person who is legally married to a shareholder at the time of death.
- 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: _____