☐ Check if this is a retirement payout. Paperwork must be filed with the Office to be eligible for this benefit.

# Wage Replacement Request For Payment Form


**IRON WORKERS DISTRICT COUNCIL OF WNY & VICINITY**

Phone: (585) 424-3510 Fax: (585) 424-3722

**E-mail: staff@iwdcbenefits.com**


| Last Name | First Name | | Social Security Number<br>XXX-XX-__________ | Cell Phone |
|---|---|---|---|---|
| Address | City | | State | Zip |

☐ **Unemployment Benefit:** You must be involuntarily laid off from work by a signatory employer. Proof that you are entitled to state unemployment (claim history details) for the week that you are requesting reimbursement must be included with this form. You cannot refuse to accept any work that has been offered to you, and you must be on the out-of-work list with the union hall. The state of NY's website is https://www.ny.gov.

Check here if this is your waiting week: ☐

❖ Claiming a waiting week for the weekending _____/_____/20____ ($**800.00/week**)
Claiming subsequent benefits for the weekending _____/_____/20____ ($400.00/week)
Claiming subsequent benefits for the weekending _____/_____/20____ ($400.00/week)
Claiming subsequent benefits for the weekending _____/_____/20____ ($400.00/week)
Claiming subsequent benefits for the weekending _____/_____/20____ ($400.00/week)

☐ **Disability Benefit:** An injury or illness that prevents you from working. You must provide satisfactory proof that you are entitled and continue to be entitled to state disability benefits for each week you seek the disability benefit.

**Check Box:** ☐ **Non-Occupational** (Not work related) $500/week or ☐ **Workers' Compensation** $400/week.

1. Claiming benefits for weekending ____/_____/20____
2. Claiming benefits for weekending ____/_____/20____

☐ **Vacation/ Sick Benefit**: You will be eligible to draw monies from your account for each week or day that you take. Under 50 y/o max is twenty (25) days, and over 50 y/o max is thirty (35) days.

**MAX BENEFIT FOR UNDER 50 YEARS OF AGE: $300 PER DAY OR $1,500 PER WEEK.**

❖ Benefits for weekending ____/_____/20_____ Over 50, Check box- ☐ $1,500 or ☐ $4,500
1. Daily Benefits for ____/_____/20_____ Over 50, Check box- ☐ $300 or ☐ $900
2. Daily Benefits for ____/_____/20_____ Over 50, Check box- ☐ $300 or ☐ $900
3. Daily Benefits for ____/_____/20_____ Over 50, Check box- ☐ $300 or ☐ $900
4. Daily Benefits for ____/_____/20_____ Over 50, Check box- ☐ $300 or ☐ $900
5. Daily Benefits for ____/_____/20_____ Over 50, Check box- ☐ $300 or ☐ $900

I certify that the above information is complete and accurate. I understand that I will be responsible for reimbursing the Fund Office for all amounts paid in connection with claims if I make any false statement(s) or misrepresentation(s) on this form or any claim form or if I conceal any information pertaining to any such claims. I understand that if I work during a week in which I took a vacation withdrawal, I reimburse my account and will be denied a vacation benefit for six (6) months. I agree to provide, upon request, with verification of any information. I understand that I must have the gross amount in my account at the time I am applying for benefits, as partial benefits are not payable.

Signature:_____________________________________________ Date: ______________

Pick up __________

Mail __________

July 2024 Payable Number:____________________