BRICKLAYERS & ALLIED CRAFTWORKERS
LOCAL #2, ALBANY, NEW YORK, HEALTH BENEFIT FUND
300 CENTRE DRIVE
ALBANY, NY 12203
Phone #: 1-800-664-8314 Fax #: 518-456-4431
www.bac2funds.com

WAGE REPLACEMENT ACCOUNT CLAIM FORM

Print Name: ____

Social Security#:_________________________ Phone #:________________________

Address:____

Benefits from your Wage Replacement Account ("WRA") are subject to federal and state income tax. The Plan is required to withhold all applicable taxes and, in some cases, the benefit may be subject to FICA. If FICA (or other mandated taxes) are required, the employee's portion will be deducted from your benefit. You might be subject to tax even if the Fund Office does not withhold taxes from the benefit. Please check with your tax advisor with questions relating to this. In addition, you may receive a W-2 Form or 1099 from the Fund at the end of the year.

Please complete a W-4 form for all WRA benefits with the exception of the Supplemental Unemployment Benefit. If the Fund Office does not have a W-4 on file, we are required to withhold based on single/zero exemptions. You may change your W-4 election twice per year; in June for July and in December for January.

Please refer to the Summary Plan Description for the complete terms and conditions of the benefits listed below. Visit www.bac2funds.com for your most current WRA balance.

Please check the benefit that you are requesting and be sure to attach the required documentation.

□ Supplemental Unemployment Benefits

I am applying for unemployment benefits from my WRA in the amount of $215 per week. I certify that I'm available for covered work and I'm also attaching documentation from NYS unemployment showing my week(s) paid. I'm claiming benefits for the week(s):

_________; __________; __________; _________; __________; ________; _________

□ Vacation Benefits

I certify that I'm actually taking a vacation. **I'm not working or receiving unemployment benefits during the weeks in which I'm applying for these benefits.** The amount of this benefit is equal to 40 hours pay at the Journeyman's base rate in my home local. I can receive up to 8 weeks vacation (from my WRA) per calendar year. The vacation week has to be within 30 days before or after date received. I'm claiming vacation benefits for the week(s) ending (Saturday):

_________; __________; __________; _________; __________; ________; _________

PLEASE SIGN BACK OF THIS FORM

□ Temporary Disability Benefits

I'm attaching a NYS disability check stub or an approved claim form. The amount of this benefit is $400 per week.

□ Workers' Compensation Benefits

I'm attaching a NYS Workers' Comp. check stub or an approved claim form. The amount of this benefit is $200 per week.

□ Dependent Care Benefits

I'm attaching paid receipts from the dependent care provider, which includes the name, address and tax ID# of the provider and the identity of the individual for whom the expenses were incurred.

□ Education Benefits

Please complete separate WRA **'Education Benefit Claim Form'** and supply all required information listed within to receive this benefit.

□ Extended Time Loss Benefits

I certify that: (1) no employer contributions have been remitted to the Fund on my behalf for a period of six (6) consecutive months; (2) I am available for covered work; (3) I have not refused and will not refuse to accept work in covered employment; and (4) I am not retired under any retirement plan. This benefit is equal to $400 per week.

I hereby certify that I'm available for work (with the exception of requests for temporary disability, vacation, or workers' compensation benefits) within the jurisdiction of the Bricklayers & Allied Craft Workers Local Union #2 and the Union is aware of my unemployment.

I hereby certify that the above statements are complete and accurate to the best of my knowledge. I also agree to reimburse the Fund and/or the Administrator to the extent of an overpayment, which is in excess of the amounts payable under the plan.

Further, I acknowledge the Fund has a processing fee regarding all benefits with the exception of the Supplemental Unemployment benefit.

ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY AGENCY OR ADMINISTRATOR FILES A STATEMENT OF CLAIMS CONTAINING ANY FALSE, INCOMPLETE INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNSHIABLE UNDER LAW.

Participant Signature: ________________________________ Date: _________________

FOR OFFICE USE ONLY

Processed by _______ Date _________ Total Amt. Req. _________ Amt. Approved _________
Reviewed by _______ Date _________ Total Amt. Req. _________ Amt. Approved _________

Amount Denied _________ Payable #_________