



**BEREAVEMENT FORM  
MUST BE SUBMITTED  
TO PERSONNEL  
WITHIN TWO DAYS OF  
RETURNING TO WORK**

**BEREAVEMENT BENEFIT CLAIM FORM**

EMPLOYEE CLAIMING BEREAVEMENT: \_\_\_\_\_

DEPARTMENT: \_\_\_\_\_

Death of: \_\_\_\_\_ on \_\_\_\_\_, relationship \_\_\_\_\_  
(Name) (Date)

DAY(S) OF THE WEEK	DATE(S)
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BEREAVEMENT:		

LATE INTERMENT DAY*:		
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Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Payment for bereavement is in accordance with the provisions of the employee's current bargaining unit agreement. Contracts are located at:

<http://www.tompkins-co.org/personnel/Contracts/index.html> for your convenience.

If a Management or Confidential employee is claiming bereavement, please refer to the White Collar agreement. The employee must provide a copy of the obituary when submitting a bereavement claim form to be eligible for bereavement pay.

NOTE: The maximum daily rate for bereavement will be the hourly salary for the position times the number of hours per day in the standard five day work week of the employee.

\* Late interment must occur weeks or months after death. Memorial services and celebrations of life are ineligible as additional bereavement days.

APPROVED: \_\_\_\_\_ APPROVED BY: \_\_\_\_\_  
(Date) (Signature of Department Head or Designee)

APPROVED: \_\_\_\_\_ APPROVED BY: \_\_\_\_\_  
(Date) (Signature of Commissioner of Personnel or Designee)

Optional: If the employee wishes a memorial donation, please complete the section below:

Organization Name: \_\_\_\_\_ Address: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

PLEASE CONTACT TOMPKINS COUNTY PERSONNEL AT (607) 274-5526 WITH ANY QUESTIONS REGARDING THIS BENEFIT.