

**Long Island Teachers Benevolent Fund**  
**COVID-19 Emergency Financial Grant Application**

The Long Island Teachers Benevolent Fund is committed to help you during your time of need or distress as a result of the COVID-19 Pandemic. A grant of \$600 per qualifying applicant has been approved by the L.I.T.B.F. Council.

Please read and complete this Grant Application. Once the entire form is fully completed, signed, and appropriate documents are attached, please return the original signed form to your Local President to be forwarded to:  
Long Island Teachers Benevolent Fund, 100 South Main Street, Suite 205, Sayville, New York 11782.

A qualifying applicant is a dues paying member of a local that is in good standing in the LITBF at the time of the Emergency Financial Grant request, is not a recipient of the Special Sandy Emergency Financial Grant, and meets one of the following criteria:

- a. Has deceased from complications of COVID-19. At which time the Local of the deceased makes application for the grant by completing the COVID-19 EFG form and submitting it, along with a \*death certificate to the Fund Coordinator.
- b. A death in the immediate family from complications of COVID-19 requiring expenditures exceeding \$3,000 "out of pocket" and not covered by insurance, (excluding co-pays and deductibles). At which time the member makes application for the grant by completing the COVID-19 EFG form and submitting it, along with a \*death certificate to the Fund Coordinator.

a. Name of deceased member : \_\_\_\_\_ NYSUT member #: \_\_\_\_\_

Was the deceased an active employee of the District/Employer at the time of death: \_\_\_\_\_

Name of individual paying funeral expenses which check will be made payable to: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Relation to the deceased: \_\_\_\_\_

b. Death in the immediate family of a member. Name of the deceased: \_\_\_\_\_

Relationship to the member: \_\_\_\_\_ Age: \_\_\_\_\_

Total Expenses: \$ \_\_\_\_\_ **(Must submit receipts that exceed \$3000.00)**

Name of the member paying funeral expenses which check will be made payable to: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

*By signing this application, I hereby attest and certify to the L.I.T.B.F. that the aforementioned loss is due to the COVID-19 Pandemic.*

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

**Must be completed by the Local President:**

Name of Local Union: \_\_\_\_\_

Signature of President of Local: \_\_\_\_\_ Date: \_\_\_\_\_