

COMMUNICATIONS WORKERS UNION
MEDICAL BENEFIT FUND CLAIM FORM

I wish to apply for a grant from the Fund in respect of **Dental/Optical/Surgical Appliances**:

BRANCH _____

GRADE _____

STAFF NO: _____

MEMBERS NAME _____ (Please Print)

MEMBERS SIGNATURE _____

HOME ADDRESS _____ (Please Print)

Contact No: _____

			Total Amount of Claim Submitted:
Claim (Please tick)	Dental	<input type="checkbox"/>	€ _____
	Optical	<input type="checkbox"/>	€ _____
	Surgical App.	<input type="checkbox"/>	€ _____

WHEN SUBMITTING CLAIMS FOR YOUR CHILDREN, PLEASE INSERT THEIR DATE OF BIRTH

PLEASE RETURN COMPLETED FORM TOGETHER WITH RECEIPTS TO:

Monica Hempenstall, Financial Officer, CWU, 575 North Circular Rd, Dublin 1

Please Note: - Treatment Date must be on the receipt. Original receipts requested for processing. These receipts will not be returned, you may need to copy your own receipts for tax purposes before submission.

RULE: Members may make one claim in each category above and subject to the limits outlined, the treatment date must be within a 12 month calendar year. All expenses must be claimed in the year that the expenditure is incurred and there will be no retrospection of claims.