COMMUNICATIONS WORKERS' UNION
MEDICAL BENEFIT FUND – CLAIM FORM

PLEASE COMPLETE THIS FORM IN BLOCK CAPITALS

Member's Name: _____ Staff Number: _____

Branch: _____ Mobile: _____

Address: _____

ONCE PROCESSED, YOUR GRANT WILL BE PAID BY ELECTRONIC FUND TRANSFER

BANK DETAILS:

NAME OF BANK: _____ *PLEASE PRINT*

NAME ON ACCOUNT: _____ *PLEASE PRINT*

IBAN: | | | | | | | | | | | | | | | | | | | | | |

ACCOUNT NO: _____ **SORT CODE:** _____

WHO IS THIS CLAIM FOR *(tick all that apply)*:

Member (You) ☐ **Spouse/Civil Partner** ☐ **Child (under 18)** ☐

Please tick box(es) and enter amount(s) in the categories that you wish to claim under. If the claim is for a Spouse/Civil Partner, please fill in their name. If the claim is for a child, please fill in their name AND date of birth:

			Name	Child's DOB
DENTAL	☐	**€** _____		**/ /**
OPTICAL	☐	**€** _____		**/ /**
SURGICAL & MEDICAL APPS	☐	**€** _____		**/ /**
TOTAL AMOUNT OF CLAIM	☐	***€*** _____		

INCOMPLETE FORMS WILL NOT BE PROCESSED

DATA PROTECTION:
The information collected here will only be used for the purpose of processing your claim from the Medical Benefit Fund and will not be shared with any third-party. If you consent to the use of your data for this purpose, please sign the form below.

SIGNED: _____ **DATE:** _____