JAMAICA CONSTABULARY WELFARE FUND
MEDICAL ASSISTANCE APPLICATION FORM

TICK AFFILIATION: POA ☐ JPF ☐ UDCA ☐

DATE OF APPLICATION: (dd/mm/yyyy) _____

APPLICANT'S INFORMATION

REG: _____ RANK: _____

SURNAME: _____FIRST NAME: _____MIDDLE NAME: _____

PERSONAL ADDRESS: _____

TELEPHONE: _____ EMAIL: _____

DIVISION OF APPLICANT: _____ EMPLOYMENT NUMBER: _____

ACTIVE MEMBER:☐ RETIRED:☐ DATE OF RETIREMENT: (dd/mm/yyyy) _____ TRN: _____

NEXT OF KIN: SURNAME: _____ FIRST NAME: _____

RELATIONSHIP: _____ ADDRESS: _____

TELEPHONE: _____ EMAIL: _____

RECIPIENT OF ASSITANCE: MYSELF: ☐ SPOUSE: ☐ CHILD: ☐

VENDOR'S INFORMATION

DOCTORS'S/ COMPANY'S NAME: _____ COST OF PROCEDURE: _____

DOCTOR'S/ COMPANY'S CONTACT: _____

APPLICANTS INSURANCE COMPANY: _____ POLICY NUMBER: _____

AMOUNT COVERED BY INSURANCE: _____ AMOUNT TO BE PAID BY APPLICANT: _____

ADDITONAL DOCUMENTATION: Receipt/Invoice for Procedure: ☐ Marriage/Birth Certificate: ☐
Where relationship is not bounded by marriage, letter from a Justice of the Peace is required to verify the relationship

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ELECTRONIC BANKING OPTION: Do you prefer for payment to be conducted via transfer: Yes ☐ No: ☐

If yes, provide Name on account: _____

Bank: _____ Branch: _____

Account Number: _____ Account type: Savings ☐ Chequing ☐

_____
Signature, Rank & Reg #

OFFICIAL USE

Does the member's contribution exceed 1 year?

Yes: _____ Page #_____

No: _____ Page #_____

Doctor: _____ Hospital_____

Cost of Surgery	*Health insurance*	*Bal. after H/ins.*	*JCWF Payment*	*Balance*
Room & Board	*Health insurance*	*Bal. after H/ins.*	*JCWF Payment*	*Balance*
Hospital Misc.	*Health insurance*	*Bal. after H/ins.*	*JCWF Payment*	*Balance*

Recommended by: _____Date (dd/mm/yyyy) _____

Approved by: _____ Date (dd/mm/yyyy) _____