JAMAICA CONSTABULARY WELFARE FUND
MEDICAL REIMBURSEMENT 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: ☐

ACCOMPANYING INFORMATION

APPLICANT'S INSURANCE COMPANY: _____ POLICY NUMBER: _____

Attached Original Receipt from Vendor: ☐ Marriage/Birth Certificate:☐

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 #_____

Payees_____

	Receipt Total	Health Insurance	Amount after Discount & Insurance	Amount by JCWF	Remaining Amount
60%					
40%					
80%					

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

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