JAMAICA CONSTABULARY WELFARE FUND
OPTICAL 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: _____

VENDOR'S INFORMATION

NAME: _____

ADDRESS: _____

COST OF GLASSES: _____

ACCOMPANYING INFORMATION:

APPLICANT INSURANCE COMPANY: _____ POLICY NUMBER: _____

Attached Quotation/Pro-Forma Invoice: ☐ 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 #_____

Vendor_____

Cost of Glasses	*Health insurance*	*Discount Received*	*JCWF Payment*	*Remaining Portion*

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

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