# JAMAICA CONSTABULARY WELFARE FUND
# OPTICAL 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: _____

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**NEXT OF KIN:** SURNAME: _____ FIRST NAME: _____

RELATIONSHIP: _____ ADDRESS: _____

TELEPHONE: _____ EMAIL: _____

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**VENDOR'S INFORMATION**

NAME: _____

ADDRESS: _____

COST OF GLASSES: _____ DATE OF PURCHASE: _____

**ACCOMPANYING INFORMATION:**

APPLICANT INSURANCE COMPANY: _____ POLICY NUMBER: _____

Attached Original Receipt/Invoice from vendor: ☐

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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 #_____**

**Payee: _____**

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

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

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