FTA WELFARE SOCIETY BENEFITS CLAIM FORM

NAME:..... TPF/EDP ..... DATE .....
SCHOOL ADDRESS :..... TEL:.....
RESIDENTIAL ADDRESS ..... TEL:.....
BANK:..... BRANCH..... A/C NO.....
MARITAL STATUS: SINGLE/ MARRIED.....

NOTE : Only Completely filled forms will be processed.

BENEFIT CLAIMED (Please tick the appropriate box)

Death	☐	Maternity	☐	Paternity	☐
Delivery	☐	Medical Aid	☐	Retirement	☐
Education	☐	Medical Local	☐	Salary Assistant	☐
Funeral	☐	Medical Overseas	☐	Natural Disaster	☐

NAME OF SPOUSE: ..... D.O.B .....
NAME OF CHILDREN ..... D.O.B .....
..... D.O.B .....
..... D.O.B .....
..... D.O.B .....
..... D.O.B .....

DETAILS OF CLAIM.....
.....
.....

Name of Doctor: ..... Tel: .....
Amount Claimed: $.....
(Attach Original Documents/Receipts and Doctors Prescription)

I certify that the information herein is correct in every respect.

SIGNATURE: .....

NATURE OF COLLECTION

PERSONAL ☐ DEPOSIT ☐ TMO ☐ CDP ☐ MAIL ☐

OFFICE USE ONLY

Number of Subscription: .....
Already Claimed Under this Benefit For The Year .....
Approved/Rejected .....

Director ..... Member ..... Member .....