SICKNESS BENEFIT CLAIM FORM

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6. **Receipts must be for €215 or more to obtain the maximum of €200**. No claim for less than €15 will be considered.

PLEASE USE BLOCK LETTERS

Name of Claimant _____ **MEMBER NUMBER** ☐☐☐☐☐☐☐

Home Address _____

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Phone Number. _____ Email. _____

NOTE: Claimant must be 2 years continuous member of the A.S.T.I.

NATURE OF CLAIM

ILLNESS: Period of Illness: **From** _____ **To** _____

Exact nature of Illness _____

Absence from school: **From** _____ **To** _____

Signature of Qualified Practitioner: _____

OTHER TREATMENT:

Tick appropriate box **Optical** ☐ **Dental** ☐ **Otological** ☐

Specify Treatment _____ Date of treatment _____

Expenses Incurred €		**Expenses Recovered** €	
Qualified Practitioner		From Agency	
Hospital		Amount(s)	
Pharmacist		These spaces must not be left blank, if no expenses recovered state None.	
Others			
Total		Total	

Balance _____

Date of joining ASTI _____ **School Number** ☐☐☐☐☐☐

Have you received any benefit from ASTI Sickness Benefit Fund within the past five years? **Yes** ☐ **No** ☐

If Yes state approximate date of claim? _____

Signature of Claimant _____ **Date:** _____

School _____ **Branch** _____

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