

SICKNESS BENEFIT CLAIM FORM

1. Only **one type of treatment** to be included on each claim form.
2. Illness must entail **7 consecutive days** absence from school.
3. Claims must be made **within 6 months of termination of illness or treatment**.
4. **€200 is the maximum** payable for Optical / Dental claims in a **5 year period**.
5. **Photocopied** receipts for expenses incurred and certified statements of expenses received must be enclosed with claim form.
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 _____

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Home Address, _____

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

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

HEAD OFFICE USE ONLY

Received in Head Office _____ Paid Up _____
Date SBF Meeting _____ Code Number _____
Notification Date _____ Paid On _____
Award _____ Entered _____

PLEASE RETURN TO: A.S.T.I., THOMAS MACDONAGH HOUSE, WINETAVERN STREET, DUBLIN 8.



Name: _____

Address: _____

Name On
Bank A/c: _____

IBAN: _____

BIC: _____

EMAIL: _____