

APPLICATION FOR ASSISTANCE

PERSONAL DETAILS

| | | |
|------------------------------|------------------------------|----------------|
| Employee Number: | | |
| Name: | | |
| Address: | | |
| Suburb: | State: | Postcode: |
| Home phone: | | Date of Birth: |
| Date joined SRA: | Work location: | |
| Classification: | Work location code: | |
| Branch: | Work phone: | |
| Weekly Net Pay: | Super/Retirement Fund: | |
| Rate of Pay: | Fortnightly contribution: | |
| Railway Returned Serviceman: | Enlisted where: | |
| Service Unit Number: | Enlisted when: | |
| Marital status: | Partner's employment status: | |
| Dependants: | | |

CURRENT STATUS

| | |
|--|---------------------------------|
| Assistance applied for: | |
| Nature of problem / reason for time off: | |
| | |
| Any time off: | First day off duty: |
| Nature of present income: | |
| Assets/investments: | |
| Annual/Long Service Leave status: | Time lost in last 12 months: |
| Sick Pay status: | Date of resumption: |
| Compensation status: | Expected date of resumption: |
| Medical Fund name: | Weekly contribution: |
| Hospital Fund name: | Weekly contribution: |
| Provident/Sick Fund name: | Weekly contribution: |
| Member of Welfare Fund: | Assistance from other agencies: |
| Date joined: | Paying rent/mortgage: |
| Amount of assistance from Fund: | Rent/mortgage amount: |
| Loss of income: | |

MEDICAL EXPENSES NOT COVERED BY MEDICAL INSURANCE

| | |
|-------------------|--------------------|
| Medical Travel: | |
| Due date: | Outstanding bills: |
| Accommodation: | |
| Due date: | Outstanding bills: |
| Medication: | |
| Due date: | Outstanding bills: |
| Hospital/Medical: | |
| Due date: | Outstanding bills: |

CURRENT OUTSTANDING BILLS

| | |
|-----------------|--------------------|
| Housing: | |
| Due date: | Outstanding bills: |
| Transportation: | |
| Due date: | Outstanding bills: |
| Domestic: | |
| Due date: | Outstanding bills: |
| Education: | |
| Due date: | Outstanding bills: |
| Other: | |
| Due date: | Outstanding bills: |

MONTHLY COMMITMENT

| | |
|----------------------|---------------------|
| Transport repayment: | Monthly repayments: |
| Housing extensions: | Monthly repayments: |
| Credit cards: | Monthly repayments: |
| Other commitments: | Monthly repayments: |

DECLARATION

I declare that to the best of my knowledge the information provided in this application is true. I hereby authorise the staff of the NSW Railway Employees Welfare Fund Inc. to enquire and gather information concerning my employment/health/benefits from the organisation for whom I work.

| | |
|--------------|-------------------------------|
| Signature: | Signature of Welfare Officer: |
| Declared at: | Case Report by: |
| Date: | Date: |

OFFICE USE

BENEFITS STATUS

| | |
|--------------|-----------|
| Verified by: | Position: |
| Verified by: | Position: |
| Verified by: | Position: |
| Verified by: | Position: |

RECOMMENDATIONS

| | |
|---------------------------------|---------------------------|
| Date of last claim: | Total of previous claims: |
| Recommended by Welfare Officer: | Committee recommendation: |
| Amount recommended: | Chairman: |
| Cheque number: | Date actioned: |

COMMENTS

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge receipt of _____ totalling \$ _____ from The Fund

I acknowledge receipt of _____ totalling \$ _____ from The Fund

I acknowledge receipt of _____ totalling \$ _____ from The Fund

| |
|------------------|
| Signature: |
| Print full name: |
| Dated: |

| | Date | Date | Date |
|---------------|-------|-------|-------|
| Telephone | _____ | _____ | _____ |
| Office visits | _____ | _____ | _____ |
| Home visits | _____ | _____ | _____ |
| Other | _____ | _____ | _____ |