SEAFARERS' WELFARE FUND

4th Floor, Trevessa House, Mer Rouge, Port Louis
Tel No.: 218-8949 Fax No.: 218-6099
Website: swf.govmu.org

APPLICATION FORM

Refund of 80% of Cost of Dental Treatment

(Maximum Rs **10,000** per calendar year)

SECTION I

(To be filled by seafarer)

Surname of Seafarer ……..…… Other Name(s) :……..……...

Discharge Book No.: Mau …….. Bank Name:……..……..……

N.I.C. ☐☐☐☐☐☐☐☐☐☐☐☐☐ Bank Account No.:…….

Address: ……..…… Phone Number : ……..

……..

I hereby apply for a refund of 80% of the cost of dental treatment and agree to abide by the rules as laid down in the dental treatment scheme provision. I am enclosing originals of the following documents: -

- ***Doctor's Certificate regarding nature of treatment***
- ***Original receipts and prescriptions***
- ***Detailed pharmacy bill (where applicable)***
- ***Detailed laboratory invoice (where applicable)***

SECTION II

I, Mr./Mrs./Miss ……..……hereby declare that the information I have given on this form is true and correct and solemnly declare that I am not covered by any such scheme. I, also, authorize any medical practitioner to disclose to Seafarers' Welfare Fund any information regarding this claim.

Date: ……. Signature: …….

NB: No Claim will be considered unless:

(a) If the check list above is enclosed

(b) The claim form is presented within six (6) months of last consultation.

Documents to be submitted with application form if not yet

- Copy of Discharge Book of the Seafarer
- Copy of Birth Certificate
- Copy of National Identity Card of Seafarer
- Proof of Address

SECTION III (For Official Use)

Mr./Miss/Mrs..... is a bona fide Retired / Active seaman holder of Discharge Book MAU .....

Signature.....

(Welfare Liaison Officer)

Date:.....

Remarks of Claims Committee (if any)

.....
.....

Entitled balance for year .....: Rs.....

Recommended amount (Rs): .....

Prepared by: ..... Date: .....

Decision:

Approved	Not approved

Approved amount in words.....

Signature ....

Chairman *Member* *Member* *Member* *Member*

Date: **.....**