

SEAFARERS' WELFARE FUND

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

APPLICATION FORM

Refund of 80% of Cost Medical Treatment (local)

Maximum Rs 17,000 (Retired only) (Every 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 with mention of nature of illness/diagnosis*
- *Original receipts and prescriptions*
- *Detailed pharmacy bill (where applicable)*
- *Detailed laboratory invoice (where applicable)*

SECTION II

I, Mr./Mrs./Misshereby 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

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: