UNIVERSITY OF EMBU STAFF WELFARE ASSOCIATION (EUSWA)

CLAIM FORM

MEMBER DETAILS

Names: …….. ID No: …….

PF No.: …… Membership No.: …… Tel. No.: ……..

NATURE OF CLAIM (Please tick appropriately)

Hospital ☐ Death ☐ Wedding ☐

CLAIM DETAILS (fill where applicable)

1. **SPOUSE'S DETAILS**

Names: …… ID No: ……...

Tel No: …… Address (postal): ……

Place of work (If any): ……..

2. **CHILD'S DETAILS**

Names: …….. Date of Birth: ……

3. **PARENTS DETAILS**

Names: …….. ID No: ……..

Tel No: ……. Address (postal): ……..…

Place of work (If any): ……..

Place of residence: ……

……..……

NOTE: Please provide copies of the following documents in regards to the claim made to enable verification:

1. Birth certificate for the child declared
2. ID card for spouse or parent declared
3. Discharge summary
4. Death certificate/ Notification of death
5. Marriage certificate

I certify that the details provided above are true.

Member's Signature: …….. Date: ……..

Chairman's Signature: …….. Date: ……..

Treasurer's Signature: …….. Date: ……..