THE NATIONAL UNION OF PUBLIC WORKERS

Dalkeith Road, St. Michael
Telephone: 426-1764
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Email: nupwbarbados1@gmail.com

APPLICATION FOR DENTAL ASSISTANCE

NIS# | | | | | | | **NAT. REGISTRATION #** | | | | | | | - | | | | |

APPLICANT'S NAME .....
(PLEASE PRINT)

MAIDEN NAME: (*if applicable*) ..... RELATIONSHIP: ..... MEM. NO. .....

ADDRESS: ..... Tel. (H) .....

..... Tel. (W) .....

DEPARTMENT: ..... OCCUPATION: .....

....
SIGNATURE OF APPLICANT DATE OF APPLICATION

FOR OFFICIAL USE ONLY

NAME OF COMPANY/DOCTOR .....

RECEIPT NO. ..... AMT. PAID $ ..... DATE .....

DATE MEMBER JOINED ..... MONTH OF LAST FULL SUBSCRIPTION .....

AMT PAID AND DATE OF PREVIOUS APPLICATIONS (*3 YEARS OR LESS*) 1. $.....

2. $..... 3. $.....

CHECKED BY *(STAFF MEMBER - PLEASE PRINT NAME)* .....

PAYMENT RECOMMENDED/NOT RECOMMENDED BY .....

APPROVED BY/NOT APPROVED BY ....
NAME *DATE* *CHEQUE NO.*

SPECIAL REASONS *(IF ANY)* TO BE NOTED!

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NB. All claims must be submitted **within 3 months** of being incurred to be eligible for reimbursement. A receipt must accompany applications from service provider or insurance claim form.