TAUMUN EMPLOYEE ASSISTANCE FUND

APPLICATION FORM

*Please Fill out Every Section in this Form

Applicant Type (Check one):

☐ **Yourself**

☐ **Dependent**

If dependent, have you enclosed a copy of government-issued identification for your dependent?

☐ **Yes** ☐ **No**

If Applying for a Dependent

Full Name of Dependent: _____

Date of Birth of Dependent (DD/MM/YYYY): _____

Applicant Information

Last Name: _____
First Name: _____
Email Address: _____
MUN ID: _____
Telephone Number: _____
Mailing Address: _____

Payment Preference:
☐ **Cheque**
☐ **E-transfer**

If E-transfer, provide email or phone number for transfer:_____

Eligible Categories Covered by the EAF

Please review the following eligible categories. Claims must fall under one or more of these areas:

A. Child and family care costs to perform employee duties
B. Eye-care costs (if not covered or partially covered by insurance)
C. Dental costs (if not covered or partially covered by insurance)
D. Physiotherapy costs (if not covered or partially covered by insurance)
E. Chiropractic costs (if not covered or partially covered by insurance)
F. Prescription drug costs

Application for the Employee Assistance Fund

Do you or your dependent currently have health care coverage from an employer, a graduate program, a spouse/partner's insurance, or any other source?
☐ **YES** ☐ **NO**

Claim Details

Which categories of claimable items do you want to be reimbursed for?
(See the list of categories above)

Was the expense accrued during the current semester?
☐ **YES** ☐ **NO**

Have you included the relevant receipt(s)?
☐ **YES** ☐ **NO**

Total amount you want to apply for: $_____

Previous Funding

Have you received TAUMUN EAF reimbursement since 01 September 2024?
☐ **YES** ☐ **NO**

If yes, which type of funding did you receive?
☐ **EAF Personal** – Amount: $_____
☐ **EAF Dependent** – Amount: $_____

Claim Summary Table

Please complete the following table for each expense. Add more rows or pages as needed.

Date of Expense	Category	Description of Expense	Insurance Coverage Amount	Amount paid out of pocket

Declaration and Signature

Please **enclose all appropriate documentation and receipt(s)** with your application.

I hereby certify that, to my knowledge, the information contained in this application is correct. I also understand that the information and supporting documents provided here are for administrative purposes only and will be kept confidential by TAUMUN.

Signature of Applicant: _____ **Date:** _____