



# Application for Child/Family Care Program

Full Name of dependant: \_\_\_\_\_

Date of Birth of dependant: \_\_\_\_\_

Have you enclosed the copy of government-issued Identification for your dependant?  YES  NO

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

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

Please mention the amount you want to apply for. \_\_\_\_\_

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

If yes, which type of funding did you receive? [Please select all that apply and mention the amounts]  Child/ Family Care Program \_\_\_\_\_  
 Health Care Program \_\_\_\_\_

For all claims, please fill out the following table. (Add additional pages if necessary.)

Category	Items (description)	Cost of item	Date paid

Please enclose the appropriate documentation and/or receipt(s) with your application.

I hereby certify that, to my knowledge, the contained information 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