

TAUMUN EMPLOYEE ASSISTANCE FUND APPLICATION FORM

| Pleas | e check the progran | m(s) that you are apply | ying for | | | |
|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|--------------------|
| | Health Care Prog | gram | | Child/Family Care Program | ı | |
| Appli | cant Information | | | | | |
| Last N | Name: | | | | | |
| First I | Name: | | | | | |
| Email | Address: | | | | | |
| MUN | ID: | | | | | |
| Telep | hone Number: | | | | | |
| Maili | ng Address: | | | | | |
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| | • | | | | | |
| B. Ey C. De D. Ph E. Ch | re-care costs where the costs exceed the costs where the costs exceed the costs exceed the costs where the costs expensions and the costs expensions. | he coverage; and/or ne Employee does not he coverage; and/or where the Employee d kceed the coverage; ar ere the Employee doe overage | t have ac have ac oes not nd/or | duties; and/or cess to vision care under a he cess to coverage under an en have access to coverage under a ce access to ce access t | existing den | tal plan, or where |
| Do y Whi | you currently have I program, a spouse/ ch categories of cla ist of categories ab | partner's insurance, o imable items do you v ove) | rom an e r any oth vant to b | e reimbursed for? (See the | | |
| | • | ed during the current relevant receipt(s)? | semeste | r: | ☐ YES | |
| Plea Hav | se mention the totale you received TAU | al amount you want to | ent sinc | or. e 01 September 2024? □ Child/ Family Care P | ☐ YES | <u></u> |
| 9 | select all that apply | and mention the amo | unts] | ☐ Health Care Progran | - | |

Application for Child/Family Care Program

| Full Name o | of dependant: | | |
|----------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------|-----------|
| Date of Birt | ch of dependant: | | |
| Have you depen | □ YES □ NO | | |
| Do you cu progra | □ YES □ NO | | |
| Which cat list of | | | |
| Was the e | □ YES □ NO | | |
| Have you | □ YES □ NO | | |
| Please me | ntion the amount you want to apply for. | | |
| Have you | ☐ YES ☐ NO | | |
| • | ch type of funding did you receive? [Please | ☐ Child/ Family Care Pro | ogram |
| select | all that apply and mention the amounts] | ☐ Health Care Program | |
| For all clain | ns, please fill out the following table. (Add addit | cional pages if necessary.) | |
| Category | Items (description) | Cost of item | Date paid |
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| Please encl | ose the appropriate documentation and/or rec | eipt(s) with your application | on. |
| information | rtify that, to my knowledge, the contained inform and supporting documents provided here are I by TAUMUN. | | |
| | | | |
| Signature o | f Applicant | Date | |