

Health Services Union

Level 2, 109 Pitt Street Sydney, NSW 2000

Phone: 1300 478 679 Fax: 1300 329 478 Web: www.hsu.asn.au Email: claims@hsu.asn.au



HSU WELFARE FUND Application Form

Please refer to the Welfare Fund By-laws and Terms of Reference before completing this application

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1. MEMBER DETAILS		
Surname	First name	
Date of Birth (dd/mm/yy)	HSU Member Number	
Employer	Occupation (
Email		
Phone (home)	Mobile (
Residential Address		
Suburb	State Posi	tcode
a) Briefly describe the events leading		

b) What welfare assistance is being sought:
c) What evidence will you provide to verify the facts:
I hereby declare that the information in this application is true, correct and complete. I understand and agree that if I make any false or fraudulent statements or fail to advise HSU NSW/ACT/QLD of any relevant information regarding my application, HSU may refuse to pay, and cancel my application.
I confirm that I have read and understood the HSU Welfare Fund By-laws and Terms of Reference.
Name (
Signature Date (dd/mm/yy)
OFFICE USE ONLY This member is ineligible for any other assistance provided by HSU
Signature Date (dd/mm/yy)