NEW ZEALAND RAILWAYS STAFF WELFARE TRUST
APPLICATION FOR BENEFITS

Attach receipts and post to: PO Box 2409, Wellington 6140

Please ensure ALL sections are completed.

Members Surname			**Initials**	**Staff No. or ID**
Claim for Family Members			**Contact Phone No.** (use number applicable in business hours)	
First name	Age DOB	Relationship		
			Mailing Address:-	
			Bank:-	
			Account Number:-	

All supporting receipts and other documents are attached to this claim.

I have claimed all refunds due to me from any medical insurance fund, medical care fund, Income Support and all other benefit societies. I certify that all particulars shown on this form are true and correct and are made in accordance with conditions of my membership.

Signature of Member_____Date_____

Notes:-

(1) Payments of all claims will be made by 'direct credit' payment to a bank account. Please enter account details in section above.

(2) Failure to provide all information will result in your claim being returned for completion.

(3) Members entitlements under the Benefits Schedule and associated Trust requirements are detailed in the Information Circular.

(4) Members wishing information regarding claims should ring the trust:-

KiwiRail Members	*43043 or 43073*
Other Members	*(04) 498 3043*
FREE PHONE	*0800 806 444*