



Benefits Claim Form

Civil Public and Services Union
Adelaide House, 19/20 Adelaide Road, Dublin 2.
Tel: 01 676 5394, 661 5389, 661 5448 Fax: 01 676 2918 www.cpsu.ie

Part One PLEASE FILL OUT THIS SECTION FULLY

First Name Surname
please print first name and surname in full

Former Name (if any) Date of Birth Day Month Year

Home Address

Post Code Staff No. Union No.

Mobile Gender M F Year Joined Union

Personal Email

Bank/CU Name

Bank/CU Account Name

Bank/CU Account No. Bank/CU Sort Code

IBAN and BIC numbers can be obtained on your bank statement.

IBAN BIC

Current Department

Location/Address

Office Tel. No. Branch

Claimant Signature _____ Section

Part Two TICK WHICH TYPE OF BENEFIT YOU WISH TO CLAIM

Dental Optical Hospital Other please specify

PLEASE ENCLOSE:
 1. Original receipt showing last day of treatment 2. Copy of current pay slip

Part Three TO BE COMPLETED AND STAMPED BY DENTIST/OPTICIAN

Date of examination/treatment Day Month Year Cost of treatment (in words)

Date payment received Day Month Year Signed Date

Part Four FOR OFFICIAL USE ONLY

Amount paid Inputted Processed

Please fill out this form as carefully as possible to ensure a speedy and accurate response to your benefit claim. Incorrect or insufficient information will delay the processing of your benefit cheque.

Your payroll number is printed on your paycheque and it is important to include this on our application form. Please submit claims between 1st January - 31st December of current year.