Colleague Support Fund (CSF)

Benefit Claim Form

Title	First Name(s)	Surname

Address & Postcode	
Phone Number	
E-mail Address	

Branch		Payroll No	
Group			

Dental/ Hearing/ Optical (Up to £90 per year) ☐
Please attach receipts

Hospital (£35 per night- 14 nights Max.) ☐
Please attach copy of hospital admission and discharge note

Specialist Fees (Up to £150 max per year) ☐
Please attach receipts

Maternity/Paternity/Adoption £100 ☐
(1 claim per member every 2 years, to be claimed no later than 6 months from the birth/adoption of the child). Please attach copy of birth/adoption certificate

IMPORTANT

Please tick the box for the type of claim you wish to apply for. Please ensure you have attached receipts etc where applicable. NB: All claims must be submitted within 12 months of treatment.

All monies reimbursed will be credited to the bank details we hold for you in Payroll

Signed: _____ Dated: _____

Please allow up to 28 days to receive payment

Please return completed form to:
The CSF Secretary, The Midcounties Co-operative, Co-operative House, Warwick Technology Park, Warwick CV34 6DA
Email to: CSF.secretary@midcounties.coop
Telephone: 01926 516202