



Trinidad & Tobago Police Retirees Association

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“Patron: Commissioner of Police”

VISION

“to participate in activities designed to stimulate
The mental and physical well-being of members”

APPLICATION FOR MEDICAL REFUND

I Reg. No.

Address

Phone # Nos. (HOME) (CELL)

do hereby apply for a refund of: Doctor’s Visit Medical Test/Treatment.

Eye Test Eye Glasses Dental Examination Dental Care

Purchase of Prescribed Drugs (*please tick the appropriate refund claim*)

In the sum of:

(\$) which was received at the Doctor’s Office or Medical Institution on
..... day of 20.....

I hereby certify that the above claim is true to the best of my knowledge and belief. I am aware that should I supply information in support of my claim which is incorrect or which I do not believe to be true my claim may be rejected.

Signature of Applicant Date

Approved for Payment by Date