

# COVID-19 RELIEF FUND APPLICATION FORM

*This application is being made for temporary FIP premium relief for the Policyholder, or Spouse/Significant Other, who has become unemployed as a result of COVID-19.*

## POLICYHOLDER

Family Indemnity Plan Certificate No: \_\_\_\_\_

Plan Type

A  B  C  D  E  F  G

First Name \_\_\_\_\_

Last Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Mailing address, if different \_\_\_\_\_  
\_\_\_\_\_

E-mail address \_\_\_\_\_

Mobile Number \_\_\_\_\_

Choose Identification

ID  DP  PP

Identification Number \_\_\_\_\_

Where is your Family Indemnity Plan Certificate held?

ORGANISATION: \_\_\_\_\_

BRANCH: \_\_\_\_\_

## SPOUSE/SIGNIFICANT OTHER

First Name \_\_\_\_\_

Last Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Mailing address, if different \_\_\_\_\_  
\_\_\_\_\_

E-mail address \_\_\_\_\_

Mobile Number \_\_\_\_\_

Choose Identification

ID  DP  PP

Identification Number \_\_\_\_\_

## Please respond to the following:

### A. EMPLOYED *(Person employed for wages or salary)*

Have you, or your spouse /significant other, become unemployed as a result of COVID-19 after March 31, 2020?

YES  NO

Employer's Name \_\_\_\_\_

Last Date of Work \_\_\_\_\_

*(dd/mm/yyyy)*

### B. SELF-EMPLOYED *(Person in business for themselves)*

Has your business, or your spouse/significant other, closed as a result of COVID-19 after March 31, 2020?

YES  NO

Name of Business \_\_\_\_\_

Last Date of Operation \_\_\_\_\_

*(dd/mm/yyyy)*

