



Hurstville & Rockdale Friendly Society Limited

Mailing: PO Box 438, HURSTVILLE BC NSW 1481

T: 02 9580 3050

E: office@handrfs.net.au

W: www.handrfs.net.au

REQUEST FOR ASSISTANCE

NAME: _____ MEMBER No. _____ (if known)

ADDRESS: _____

SUBURB: _____ POSTCODE: _____

EMAIL: _____ PHONE: _____

The Assistance Requested is for

- ☐ Private Prescription (Please attach Official Pharmacy Receipt)
- ☐ Items for management of a medical condition
All requests are to be accompanied by a letter or recommendation from a health practitioner and a Tax Invoice (Hearing Aids: Tax Invoice only)
- ☐ Newborn Assistance (Please attach certified Birth Certificate)
- ☐ Funeral Assistance (Please attach certified Death Certificate)
- ☐ Significant and Multiple Medical conditions (All requests are to be accompanied by a statement indicating the degree of financial burden and a statement from a Medical Practitioner certifying the condition (s))

Please complete the section below. *

*Types of costs incurred in living with the significant and multiple medical conditions (s):

Approximate cost per month: \$ _____

- ☐ I certify that the assistance requested is only for persons covered under my membership.
- ☐ I certify that no government assistance (e.g. any Medicare benefits, NDIS, Home Care & Aged Care Packages) or private health fund support has been received.

Signed: _____ Date: _____

Bank Account Details (Member's Account or Joint Account Only)

BSB : _____

Account Number: _____

Account Name: _____