



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)
- ☐ Mobility Aids (Please attach Tax Invoice)
- ☐ Hearing Aids (Please attach Tax Invoice)
- ☐ Newborn Assistance (Please attach Birth Certificate)
- ☐ Funeral Assistance (Please attach Death Certificate)
- ☐ Chronic medical illness (Please attach annually updated Doctor's certificate and fill in below *)

*Types of costs incurred in living with the chronic condition (s):

Approximate cost per month: \$_____

☐ I certify that the assistance requested is only for persons covered under my membership.

Signed: _____ Date: _____

Bank Account Details

BSB : _____

Account Number: _____

Account Name: _____