



CONFIDENTIAL

HEALTH FUND APPLICATION FOR REFUND OF FEES

THE APPLICATION FORM HAS TO BE FILLED OUT CORRECTLY AND COMPLETELY IN ORDER TO BE HANDLED. TELEMAR STUDENT ASSOCIATION MAY COUNTER CHECK THE GIVEN INFORMATION.

GO TO WWW.SITEL.NO/HEALTHREFUND FOR GUIDELINES.

SURNAME _____ FIRST NAME _____ EMAIL _____

EDUCATIONAL INSTITUTION(line under) HiT: PORSGRUNN /BØ / NOTODDEN /RAULAND

FU (Folkeuniversitetet)

FIELD OF STUDY _____

ADDRESS (during academic year) _____

POSTAL CODE _____ CITY _____

PHONE NUMBER _____ DATE OF BIRTH _____ STUDENT NO. _____

STARTED ACADEMIC YEAR _____ FINISHES ACADEMIC YEAR _____

APPLICATION IS REGARDING (cross out):

____ REFUNDING OF CONTRIBUTORY FEES/ FREE CARD

____ PRIVATE PRACTICE PSYCHOLOGIST/PSYCHIATRIST

____ CHIROPRACTIC OR PHYSICAL TREATMENT

____ TRANSPORTATION EXPENSES

____ EXPENSIVE ILLNESS OR INJURY

____ TESTING FOR READING/WRITING DISABILITIES

____ GLASSES

THE TREATMENT COSTS THE TOTAL OF NOK. _____. THE EXPENSES MUST BE PROVEN.

THE FUNDS WILL BE TRANSFERRED TO YOUR BANK ACCOUNT.

ACCOUNT NUMBER: _____

DATE AND CITY _____ SIGNATURE _____