South East Counties Benevolent Fund

(Registered Charity Number 1012734)

Application for a Grant

Please return this form to: Mr Lionel Woodward – Chair of Trustees
6 Singleton Road, Broadbridge Heath, Horsham, West Sussex, RH12 3NP Tel: 01403 241927

All requests for application forms **MUST** be made to the Hon Secretary of the Benevolent Fund within 14 days of the injury or a reduced grant may be made or the application may not be considered. All questions must be answered in full. No request for assistance will be considered unless Benefits Agency Payment Statements and/or S.S.P Verification and a medical certificate are received by the Fund Secretary (see over)

Surname of Applicant | First Names

Full Postal Address

Post Code:

Telephone No: | Age: | Marital Status:

Dependants (provide full details including ages)

Were you in employment at the date of injury? YES/NO If yes provide details of employment below.

Occupation | Employee No (if any) | Length of Service

Name & Address of Employer/Business

Post Code:

Basic Wage (after deductions Inc Tax, National Insurance & Pension contributions)

£ Week/Month /Year *

If self employed Name & address of your accountants

Post Code:

Are any part of your wages/salary being paid Yes/No *	If yes, how much after all deductions £
How Much did your Club contribute to the fund last season? £	How much has your Club contributed to the fund this season? £

Applicants Connection with the game. | How long a member of the club Years Months

Name of Club

What is the nature of the injury?

Date of Injury	Match

Competition

How long have you been incapacitated?	How long are you likely to be incapacitated?

What is your club doing to assist you?

Provide details or income Whilst incapacitated.

a) Statutory Sick Pay	£	:
b) Incapacity Benefit	£	:
c) Other State Benefits	£	:
d) Club Insurance	£	:
e) Other sources	£	:
Weekly/Monthly* TOTAL	**£**	**:**

National Insurance MUST Be applied for
On each line you must state an amount, nil or information to follow.
Provide full details of C & D

Details and Address of Doctor

Post Code

MIS-STATEMENTS, INCORRECT INFORMATION OR WITHOLDING OF ESSENTIAL INFORMATION MAY RENDER THIS APPLICATION VOID OR RESULT IN A REDUCED GRANT BEING PAID.

I declare the answers and information provided in this application are accurate and true and I have received and read a copy of the guidance notes for Applicants and Clubs. I authorise the Sussex County Football Association to make such enquiries as are considered necessary in connection with this application.

Signature of Applicant	Date

Verification of SSP/Incapacity Benefit/Income Support Enclosed / To Follow *	Medical Certificate (confirming initial period of Incapacity or Estimates of Dental Treatment. Enclosed / To Follow *

I declare (1) I have checked that all the sections of the application have been fully completed and (2) as far as I am aware the answers given in this application are correct and (3) I am satisfied that the applicant is in necessitious circumstances.

Authorised Club Signatory Chairman/Secretary/Treasurer *	Date

Name and Address of Club Official

Post Code

Note: Incorrect or inaccurate information provided on this form or in subsequent correspondence may result in a charge of misconduct being issued by the Sussex County Football Association to both the applicant and/or Club.

* **Delete as appropriate**