EXPENSE CLAIM - Medical Disability Pension

PENSIONS ADMINISTRATION DIVISION
Department of Finance, P.O. Box 8700, St. John's, NL, A1B 4J6
Fax (709) 729-6790

PERSONAL DATA

Name: _____ **S.I.N.:** _____

Telephone: ( ) _____

Mailing Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

Purpose of Trip: _____

Date	Particulars	Depart / Return Time	Meals	Hotel	Travel	Private Vehicle Kms	H.S.T.
	Claim Total: $						
	Total Payment Amount: $						

I CERTIFY THAT THE WHOLE OF THE EXPENSES INCURRED BY ME WERE FOR THE PURPOSE OF PROVIDING MEDICAL INFORMATION TO THE PENSIONS ADMINISTRATION DIVISION AND ARE IN ACCORDANCE WITH TREASURY BOARD TRAVEL RULES

Claimant's Signature _____ Date _____ Pension Administration Division _____ Date _____

The personal information collected or provided as part of the application process will only be used for purposes relating to the operation of the relevant pension programs and for statistical reports. All information will be kept confidential and will not be disclosed to third parties without your consent unless required or authorized by law. If you have any questions or concerns please contact the Pensions Administration Division.