BORESHA SACCO SOCIETY LTD.

(FORMERLY BARINGO TEACHERS SACCO SOCIETY LTD)

HEAD OFFICE.
Market Rd,Teachers Plaza
P.O. BOX 80 - 20103,
ELDAMA RAVINE.

Phone Contacts.
(+254)
Tel: 020-8024881/Fax: 051-8009020
Cellphone: 720-200-689/0734-200-004

CS: 2549

HEAD OFFICE - CS: 2549/MWF/09/2010

BEREAVEMENT FORM - 2010

THIS FORM BE FILLED WITH HONESTY AND TRUTH BY BEREAVED MEMBER; WHEN IMMEDIATE FAMILY MEMBER DIES

Immediate Family shall mean Biological Mother or Father or Child, Husband/Wife. OTHERS WILL NEVER BE ACCEPTED. **WARNING – False Claims shall result in Heavy Penalties!!!**

The Society shall use all means to Ascertain the truth. Any False Claims will attract a Penalty of same Amount claimed to be recovered from the Savings/Deposits or as Loan. Be warned before you fill this Form!!! Avoid Legal Action !!!

A) MEMBER

I_____M/No_____P/TSC No_____

Work Place_____Address_____

Tel. No.Landline_____Mobile No_____

HEREBY REPORT
The Death of My _____Who Died on_____

Names_____

ID Or Birth Certificate of The Deceased No_____Hospital_____

Doctor's Name_____Tel. No._____

I , therefore, apply for Members Welfare Fund Kshs._____
(Note that Father/Mother Kshs.10,000/=. If Child, Husband or Wife Kshs.25,000/=).

Burial Certificate Copy & Original ID or Birth Certificate Copy for the Deceased is hereby attached.

Comments_____

FOSA/SASA Account Number_____ Branch_____

Bereaved Member's Signature_____ Date_____

CONFIRMATION BY DELEGATE:

I _____M/No_____P/TSC No_____

Representing Members in:-_____Zone, Confirm that I know this case.

Sign_____Date_____Address_____Mobile No._____

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Bereavement Cont'd

C) H/M or Officer in Charge : I Certify that my Member of Staff
Mr./Mrs./Miss_____

P/TSC No_____ is bereaved by death of his/her_____

Signature_____ Date_____Official Stamp_____

Name_____ Address_____

Telephone Number_____ Mobile Number_____

D) CHIEF: It is True That Mr./Mrs./Miss_____

lost his/her_____ on_____

and Burial Certificate Number_____dated _____ was issued.

Signature_____ Date_____Official Stamp_____

Name_____ Address_____

Telephone Number_____ Mobile Number_____

E) OFFICIAL USE ONLY **M.W.F. REGISTER NO._____**

M/No._____P/TSC No._____

M.W.F. Contribution Kshs._____as at_____

Upon death of His/her_____ Kshs._____ be paid.

This is the 1st, 2nd or 3rd_____ Claim this year_____

Total Claimed Kshs._____(Maximum Limit Kshs.50,000/= in a Financial Year).

Remarks_____

Checked by (Name) _____Signature_____Date_____

MEMBERS WELFARE OFFICER

Recommended Payment Kshs._____ In words_____

Cheque/Fax No._____FOSA/SASA A/C No._____ Branch_____

Confirmed by(Name)_____ (Signature)_____ Date_____

ACCOUNTANT

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Sign_____ Date_____ Sign_____

GENERAL MANAGER **TREASURER**

No payments shall be made before Confirmation of Claims from Officials concerned and Some Members in the Institution where the Claimant works. If in doubt, Board Members should Investigate.