



CLAIMANT INFORMATION

SURNAME FULL NAMES	STAFF NUMBER: (Please confirm with HR)																																																						
ID NUMBER:																																																							
A FULL-TIME STAFF MEMBER	A PART-TIME STAFF MEMBER	NOT A STAFF MEMBER	INCOME TAX NO:																																																				
POSTAL ADDRESS:														POSTAL CODE:																																									
RESIDENTIAL ADDRESS														POSTAL CODE:																																									
TELEPHONE:														WORK														HOME														CELL													

BANK DETAIL

BANK:														BRANCH:													
TYPE OF ACCOUNT:	SAVINGS				CHEQUE				TRANSMISSION				(NO CREDIT CARD ACCOUNTS)														
ACCOUNT NUMBER:																											
SIGNATURE OF CLAIMANT:														DATE:													

SUBJECT DETAIL

SUBJECT CODE:																
SUBJECT NAME:																
EXAM	FEBRUARY EXIT SPECIAL		MAY MAIN		MAY RE- EXAM		AUGUST EXIT SPECIAL		NOVEMBER MAIN		NOVEMBER RE-EXAM		BLOCK			
SERVICES RENDERED	EXAMINER				INTERNAL MODERATOR				EXTERNAL MODERATOR				RE-MARK			
CAMPUS:	Arcadia		Arts		eMalahleni		Ga- Rankuwa		Nelspruit		Pretoria		Polokwane		Soshanguve	
NO. OF SCRIPTS MODERATED																

FOR ADMINISTRATION OFFICE USE ONLY!

I	(name & surname of administrator), hereby confirm that the claim form is completed in full and correct.																		
CAMPUS:					EXT:					SIGNATURE:					DATE				
R	AMOUNT												Supervisor, Salaries						
Entity Manager (Responsible for Payment)														Date					