CHARITABLE COMPANY LIMITED
(A subsidiary of Tauhara North No.2 Trust)

PO Box 490, Taupō 3351
93 Heuheu Street
Taupō 3330
Email: team.grants@tauharano2.co.nz
www.tauharano2.co.nz
Phone: 07 376 7533
0800 828 427
Fax: 07 376 7539
0800 828 428

HEALTH GRANT APPLICATION FORM

For all Health Grant Categories (Vision, Dental, Dentures, Orthodontics, Hearing and General Health) Applications must include quotes and/or and receipts for costs incurred between 1 July to 30 June (CCL Financial Year)

All Health Grants offered by CCL are available to Owners, descendants and whanau[1] as recognised by Tauhara North No.2 Trust. Health Grants are issued for services provided within New Zealand only.

The Household Representative must complete this form for General Health reimbursements on behalf of the Household. Please call 0800 828 427 if you are unsure.

Please tick the Health Grant type/s below that this application is for (You can tick more than one as long as it is for the same applicant).

GRANT TYPE (please tick)	CATEGORY	PURPOSE	VALUE
	General Health	For primary care consultations including GP visits, prescriptions and alternative primary care consultations with registered providers such as homeopaths, healers and acupuncturists.	Up to NZ$600.00 **per household**[2] per financial year. Applications must be made through a nominated Household Representative.[3] ***Reimbursement only***
	Vision	Optometrist consultation fees, contact lenses, prescription glasses and reading glasses.	Up to a total of NZ$1,100.00 for the first Vision Grant **per person** in any Financial Year (in total – not per type of cost) and then $1,100.00 every two (financial) years thereafter (in total – not per type of cost). ***Paid direct to the service provider or Reimbursement***
	Dental	Dental consultation fees and dental work.	Up to NZ$440.00 **per person** per financial year. ***Paid direct to the service provider or Reimbursement***
	Dentures OR Orthodontic	For the consultation, purchase of new dentures, or for the replacement or repair of existing dentures. **OR** For Orthodontic treatment costs, consultation and ongoing treatment	Up to NZ$1,650.00 **per person** per financial year for **either** Denture **OR** Orthodontic services or products ***Paid direct to the service provider or Reimbursement***
	Hearing	Hearing specialist consultation fees and the purchase, replacement or repair of hearing aids.	Up to NZ$1,100.00 **per person** per financial year. ***Paid direct to the service provider or Reimbursement***

[1] "Whanau" includes registered individuals who are Whangai; legally adopted child of an owner or descendant; step child/grandchild etc; spouse/partner of an owner or descendant.

[2] General Health reimbursements will only be made for costs incurred by members of the Household who are registered with Tauhara North No.2 Trust.

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SECTION ONE: APPLICANT DETAILS

First Name:_____ Surname:_____

Also known as:_____

Gender: M / F Date of Birth: ____ / ____ / _____ Age: ____ Shareholder Number (if known): _____

*(Only complete details below if this is your first application **or** your details have changed since your last application)*

Residential Address: _____

_____ Post Code: _____

Mailing Address if different to above: _____

_____Post Code: _____

Email address: _____

Daytime phone number: _____ Other number:_____

SECTION TWO: CONSENT TO ACCESS INFORMATION

Consent to access information:

In some circumstances, where CCL is paying a health grant directly to a service provider, CCL staff may need to contact the service provider to obtain clarification or details relating to the application. In the event that this is necessary, CCL wish to obtain your consent to contact the service provider. This consent will only be relevant to this particular application. Please indicate whether you consent to CCL contacting the service provider: **Yes** ☐ **No** ☐

SECTION THREE: PAYMENT DETAILS

Payment details **(Please provide receipt/s for reimbursements and/or quotes for payments to be made direct to the provider)**

How much funding are you requesting in this grant application? $_____

For reimbursements:

Amount Payable to: _____

Account Name: _____ Account Number: _____

**Please provide a bank verified account number, deposit slip or internet banking print out if Charitable Company Ltd does not already have this.*

SECTION FOUR: DECLARATION

I hereby certify that the information in this application is true and correct to the best of my knowledge.

Signature: _____ Date:_____

If you have completed this form on behalf of an under-18 year old please complete the following:

Your name: _____ Your relationship to the applicant: _____