**APPENDIX A**

**MATERNITY INSURANCE CLAIM FORM**

SCHOOL.............................................................................................................

MEMBER OF STAFF CLAIMED FOR..................................................…………….

POST: (Teacher/School Administrator/Admin Assistant/NNEB/Welfare Assistant/Caretaker/Cleaner/SMSA/Other ……………………………………….

Full Time/Part Time (If part time state no. of hours worked) …………………………

Date of Commencement of Service at the School............................................................

Date of Commencement of Maternity, Parenting/Carer Leave........................................

Has the Member of Staff Undertaken to Return to Work Following Maternity Leave Yes/No

 Date of Return ………………………………………………………………

Signed..............................................................................Headteacher

Date.........................................

Please return to: Schools HR,

 5th Floor SW,

 Perceval House,