



Please return this form to:
 5 Westgate Business Park,
 Kilrush Road, Ennis,
 Co. Clare

LoCall 1890 473 473
 Fax 065 6862504

Claim Form

Thank you for notifying us of your claim. All claims must be made within 6 months.
PLEASE USE BLACK INK AND BLOCK CAPITAL LETTERS AND ENSURE YOU SIGN THE DECLARATION ON THIS FORM.

To be completed by the Policyholder

A Surname _____
 Forenames _____
 Address _____
 _____ Postcode _____
 Daytime Telephone _____ Email _____



Registration No _____ **Signature** _____
 Employer _____ **Date** _____

(If premiums are deducted from pay/pension)

Payment of your claim will normally be made direct to your Bank/Building Society account. Please supply your details:

Name of the account holder(s) _____

Account Number

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This section must be completed in full for all claims (except for dental / optical / GP / A&E / prescription / chiropraxy and birth grant) and is also required for every continuing claim. Missing information may delay claim settlement.

B Please answer the following questions in full:

1. What diagnosis has been given as the reason for the admission to hospital or for the consultation or for treatment etc.? If no diagnosis has been made, please describe your symptoms.

2. When did symptoms of this condition/problem first begin?

3. When was the family doctor first consulted about them?

4. Was the illness connected in any way with a previous one? **YES / NO**
 If yes, please state date of previous illness _____

Hospital and Hospice

C Patient – Surname _____ Forenames _____
 Date of Birth _____ Contributor Spouse/Partner Child under 21

TO BE COMPLETED BY THE PATIENT OR GUARDIAN OF CHILD UNDER THE AGE OF 21:

*Please delete as necessary

* I the patient/guardian of the named above, was an in-patient at the Hospital/Hospice mentioned below and authorise an official from that establishment to confirm the dates of my/my child's admission and discharge and to indicate to the HSF health plan the nature of my/the patient's illness by using one of the following categories: General, Geriatric, Psychiatric, Accident, Birth Grant-Ante/Post, Birth Grant - Confinement.

Signature (Patient or Guardian) _____ Date _____

Name of Hospital/Hospice _____

Address _____

Ward _____ Hospital No. (if known) _____

Date of Admission _____ Date of Discharge _____

PLEASE NOTE – HSF HEALTH PLAN WILL CONTACT THE HOSPITAL OR HOSPICE, YOU DO NOT HAVE TO. HOWEVER IF YOU HAVE AN ORIGINAL HOSPITAL DISCHARGE CERTIFICATE PLEASE ENCLOSE IT.

Day Case Surgery/Treatment

This benefit is **ONLY** for planned day case surgery/treatment, **NOT** for emergency admissions for one day nor for outpatient appointments.

PLEASE ATTACH A COPY OF YOUR DAY CASE NOTIFICATION LETTER (if available).

D Patient Surname _____
 Forenames _____
 Date of Birth _____ Policyholder Spouse/Partner Child under 21
 Name of Hospital _____
 Ward _____ Date of Stay _____

To be completed by the hospital

Signature of authorised hospital official confirming day stay & occupancy of a bed. Outpatient clinic appointments to be excluded:

Designation of above official _____

Official Stamp of Hospital

Other Categories

E Receipts enclosed Totalling € _____ In words _____
 Full name(s) of person(s) to whom the receipt(s) refer(s): _____

| Please tick the appropriate box to indicate the nature of the claim(s). | HSF USE |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|
| 1. GP Visit <input type="checkbox"/> Prescription Charge <input type="checkbox"/> A&E Visit <input type="checkbox"/> | |
| 2. Specialist/Investigations <input type="checkbox"/> | |
| <p>PLEASE NOTE due to Tax Relief at Source we cannot pay any claims if this section is not completed. Please only tick ONE box which represents the main treatment you received.</p> 3. Optical Treatments <input type="checkbox"/> Dental Treatments: Routine Checkup, & Scaling/Filling of Teeth <input type="checkbox"/> Extraction <input type="checkbox"/> Provision/Repairing of Artificial Teeth/Dentures <input type="checkbox"/> Crowns <input type="checkbox"/> Tip Replacing <input type="checkbox"/> Veneers/Rembrant Type Etched Fillings <input type="checkbox"/> Gold Posts <input type="checkbox"/> Gold Inlays <input type="checkbox"/> Bridgework <input type="checkbox"/> Endodontics - Root Canal Treatment <input type="checkbox"/> Orthodontic Treatment <input type="checkbox"/> Periodontal Treatment/Dental Implants <input type="checkbox"/> Hospital Surgical Extraction of Impacted Wisdom Teeth <input type="checkbox"/> | |
| 4. Birth/Adoption Grant <input type="checkbox"/> | |
| 5. Physiotherapy <input type="checkbox"/> Osteopathy <input type="checkbox"/> Chiropractic <input type="checkbox"/> Acupuncture <input type="checkbox"/> Homoeopathy <input type="checkbox"/> Chiropody <input type="checkbox"/> | |
| 6. Surgical Appliances/Hearing Aids <input type="checkbox"/> | |
| There are special claim forms for: Fracture/Temporary Disability <input type="checkbox"/> Permanent Disability <input type="checkbox"/> <small>Please refer to brochure for details of injuries applicable and tick box to request form. (Scheme €4.25/€20.50 and above only).</small> | |

The receipts must:

a) be originals, not photocopies; (credit/debit card receipts submitted on their own cannot be accepted) b) include the practitioner's stamp/name and date of issue; c) include the patient's name; d) state the type of service and items provided; e) be for a service covered by the HSF categories only and not for any insurance premiums paid to cover that service; f) be for a service for which payment has been met by a person registered under HSF health plan.

For a birth or adoption grant claim, please enclose an original full Birth/Adoption Certificate which will be returned to you promptly by post (if you require a Special/Recorded service please include a self addressed envelope with the correct postage and completed official delivery form). Should it be necessary for my claim to be verified, I authorise the HSF health plan to approach the relevant clinical practitioner and authorise that practitioner to supply information to enable my claim to be processed.

We wish to advise that in order to provide a faster and more secure method of payment; settlement of your claim will be made directly into the bank details we hold. If we do not have your bank details please provide these under Section A of the attached claim form.

SIGNATURE OF POLICYHOLDER _____

DATE _____

Checklist

1. Have you enclosed your receipts?
2. Have you signed the form?
3. Have you completed all of the relevant sections?
4. Have you completed Pages 1 & 2?
5. Have you completed or checked your bank details are correct?