

Application to be a contributor to HSF health plan

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|-------------------------|
| Date Received – HSF use |
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|----------------------------|--|--|--|--|--|
| Registration No. – HSF use | | | | | |
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THIS PART MUST BE COMPLETED IN ALL CASES

| | | | | | | | |
|--|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|--------------------|
| I apply to join HSF health plan at the weekly rate indicated (PLEASE TICK) | <i>Scheme 200</i> | <i>Scheme 300</i> | <i>Scheme 425</i> | <i>Scheme 550</i> | <i>Scheme 750</i> | <i>Scheme 950</i> | <i>Scheme 1150</i> |
| | €2.00 | €3.00 | €4.25 | €5.50 | €7.50 | €9.50 | €11.50 |

Employer

Surname

Forename Other Initials Mr/Mrs/Miss Ms/Other

Address

Email Tel: Work

Date of birth Contributor Day Month Year Tel: Home

Date of birth Partner Day Month Year Fax

Partner's Surname

Partner's Forename(s)

| | |
|---|-----------------------------|
| If already covered by HSF please state: | |
| Contribution | Registration No. (if known) |

| Children (<i>children must be under 18 years of age</i>) | | Sex | Date of Birth |
|--|---------------------|-----|---------------|
| Child's Surname | Child's Forename(s) | | |
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| | | | |
| | | | |

HSF health plan uses the information given above for its own purposes. Any communications which you may receive are directly related to HSF services and those of the HSF Charity.

Declaration

I declare that I and all persons covered by this application for whom claims may be submitted are in good health and are not receiving or needing any form of medical treatment and have not had any medical conditions in the past for which treatment is not at present necessary. If this is not the case I have declared all relevant health information on the reverse of this form.

I understand that no claim will be accepted in respect of any conditions which existed or for which symptoms were present before registration or which began during the qualifying periods; nor for any developments of existing conditions; nor for any recurrence of conditions which have existed in the past; nor for any hereditary or congenital conditions which may already exist but which manifest symptoms only after cover commences, and that this application is accepted only on these terms. (Contributors increasing from one scheme to another may be able to receive benefit at their former scheme rate for such conditions and will be advised if this is possible).

I confirm that no advice has been received regarding this application from HSF or my employer. I agree to HSF and Chubb holding data relevant to my scheme registration.

I agree to abide by HSF rules and conditions and the right of the Board of Directors to vary them and the range or rates of benefits or contributions if deemed necessary. I declare that all the information I have given on this application form is true and complete to my knowledge and belief and that if found to the contrary HSF shall be free to cancel cover at any time.

| | |
|--------------------------------|---------------------------|
| Signature <input type="text"/> | Date <input type="text"/> |
|--------------------------------|---------------------------|

IMPORTANT: PLEASE COMPLETE THE MEDICAL INFORMATION SECTION ON REVERSE (PAGE 14)

Medical information

Your cover has to be based on the information you supply on the whole of this application form. You must be satisfied that it is correct to the best of your knowledge and belief. To withhold or fail to disclose relevant facts (or to knowingly give false information) about the health and/or treatments of all persons to be covered could affect the benefits we are able to offer or could seriously influence your cover in the event of a claim. It could also lead to termination of cover or even be considered a criminal offence.

Please state any long term/chronic/congenital conditions even if at present under control and indicate to whom these apply. PLEASE TICK BOX (if using 'Other' section, please state conditions in full and avoid abbreviations)

| Name | Condition/Illness | Date symptoms began |
|------|---|---------------------|
| | <input type="checkbox"/> Arthritis PLEASE STATE PART(S) OF BODY AFFECTED BELOW <input type="checkbox"/> Asthma/Chest problems <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> Kidney disease <input type="checkbox"/> Liver disease <input type="checkbox"/> Raised blood pressure/Angina <input type="checkbox"/> Congenital (conditions from birth) PLEASE STATE <input type="checkbox"/> Other PLEASE STATE | |

Please list other illnesses/operations, either current or in the past (stating conditions in full and avoid abbreviations). Also list any medication being taken currently and state the condition/illness requiring the treatment.

| Name | Condition/Illness | Date symptoms began |
|------|-------------------|---------------------|
| | | |

| | |
|---|------|
| Signature  | Date |
|---|------|

Authority deduction from pay HSF health plan

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|----------------------------|--|--|--|--|--|
| Registration No. – HSF use | | | | | |
| | | | | | |

Employer

Surname

Forename Other Initials Mr/Mrs/Miss Ms/Other

PLEASE COMPLETE THE SECTIONS BELOW WHICH ARE APPLICABLE TO YOUR PARTICULAR EMPLOYER

Departments/
Branch/
Location

PPS Number

Staff Number

Pay/Pension Office

This authority replaces the existing authority for deductions of

New deduction

Pay frequency PLEASE TICK

Weekly
 Fortnightly
 Four weekly
 Monthly

I authorise my employer to deduct from my pay/pension the above sum (or such future amounts as apply for my registration), and remit to HSF health plan. If my pay/pension is not paid for any reason any contribution arrears should be deducted when my income resumes.

Signature Date

Your pay department will commence deductions as soon as possible after receipt of this mandate form from HSF health plan. Your pay advice should be checked to ensure that this request has been correctly applied.

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|----------------------------|----------------------|----------------------|
| Recorded in Wages Dept. | Initials | Date |
| | <input type="text"/> | <input type="text"/> |

| | | | |
|--------------|----------------------|----------------------|--------|
| Noted by HSF | Initials | Date | New |
| | <input type="text"/> | <input type="text"/> | Change |

**To: HSF HEALTH PLAN
FREEPOST
Clare Road Mall
Clare Road
Ennis
Co Clare**

TEAR ALONG PERFORATION