

# Application for membership of HSF health plan

Date Received – HSF use

Membership No. – HSF use					

THIS PART MUST BE COMPLETED IN ALL CASES

I apply to join the HSF health plan at the weekly rate indicated (PLEASE TICK)

<i>Scheme 3</i>	<i>Scheme 6</i>	<i>Scheme 9</i>	<i>Scheme 12</i>
€3	€6	€9	€12

Employer

Surname

Forename  Other Initials  Mr/Mrs/Miss  Ms/Other

Address

Tel: Work  Email

Tel: Home  Date of birth Day  Month  Year

Fax  If already an HSF member please state: Contribution  Membership No. (if known)

Benefit payments will normally be made directly to your bank/building society account.\* Please give details:

Name and full postal address of your bank and branch

Name of the account holder

Sort Code  –  –  Account Number

\* It will be possible to request cheque payment by indicating this on the claim form.

*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 Charitable Trust.*

## Declaration

I declare that I am in good health and 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 membership 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 membership commences, and that this application is accepted only on these terms. (Contributors changing schemes may be able to receive benefit at their former scheme rate for such conditions and will be advised if this is possible).

I agree to abide by HSF membership and benefits 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 to my best knowledge and belief and that if found to the contrary HSF shall be free to cancel the membership.

Signature

Date

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

TEAR ALONG PERFORATION

## Medical information


Your membership will 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 your health and/or treatments 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 membership or even be considered a criminal offence.

Please state any existing long term/chronic conditions even if at present under control.

PLEASE TICK BOX (if using 'Other' section, please state conditions in full and avoid abbreviations)

Condition/Illness	Date symptoms began
<input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> Raised blood pressure <input type="checkbox"/> Asthma <input type="checkbox"/> Arthritis <input type="checkbox"/> Other (PLEASE STATE)  <hr/> <hr/>	

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.

Condition/Illness	Date symptoms began
Signature 	Date

# Authority deduction from pay HSF health plan

The Hospital Saturday Fund

Membership No. – HSF use

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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

Rank or Grade  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

If any application for membership is agreed, I hereby authorise my employer to deduct from my pay/pension until further notice in writing from me the above sum by way of contribution in accordance with the rules and regulations of HSF health plan, and to pay the amount so deducted to HSF health plan. Should I not receive a salary/wage for any reason and deductions cease temporarily I authorise arrears of HSF contributions to be deducted when my salary/wage 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.

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