

Application to join HSF health plan

THIS PART MUST BE COMPLETED IN ALL CASES I apply to join HSF health plan at the monthly rate indicated (net of partial Standard Rate Tax Relief at source) PLEASE TICK (✓)

Scheme 950	Scheme 1450	Scheme 2050	Scheme 2650	Scheme 3600	Scheme 4550	Scheme 5500	Scheme A	Scheme B	Scheme C
€9.50	€14.50	€20.50	€26.50	€36.00	€45.50	€55.50	€52.50	€66.70	€81

Surname

Forename Other Initials Mr/Mrs/Miss Ms/Other

Address

Postcode

Email Tel: Work

Date of birth Policyholder Day Month Year Tel: Home

Date of birth Spouse/Adult Dependant Day Month Year Mobile

PPS Number

Spouse/Adult Dependant's Surname

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

Children (children must be under 21 years of age)

Child's Surname	Child's Forename(s)	Sex	Date of Birth

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 Hospital Saturday Fund.

Declaration
This application is made on behalf of myself (the contributor) and any adult and child dependants listed above. I confirm that no advice has been received regarding this application from HSF. 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, with notice. 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 I understand that HSF may need to impose some restrictions on my cover.

Signature Date

BY COMPLETING HEALTH INFORMATION BELOW YOU WILL ASSIST US IN THE ADMINISTRATION OF YOUR POLICY. FAILURE TO DO SO WILL NOT AFFECT THE REGISTRATION.

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. To give false information could be considered to be a fraudulent act and lead to termination of cover.
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"/> Clinical Obesity <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 <input type="text"/>		Date <input type="text"/>

Instruction to your Bank or Building Society to pay Direct Debits

Originator's Identification Number

3 0 2 1 7 0

Originator's Identification Membership Reference Number



Please complete parts **1** to **4** to instruct your bank to make payments directly from your account. Then return the form to: **HSF health plan, FREEPOST, 5 Westgate Business Park, Kilrush Road, Ennis, Co Clare.**

Please tick (✓) your preferred date:

Also tick (✓) your preferred period:

This is not part of your instruction to your bank

5th

20th

Monthly

Quarterly

6 Monthly

Annually

1. To the Manager of (Bank/Building Society Name & Address)

2. Name of account holder

3. Sort Code

Account Number

 — —

Banks may refuse to accept instructions to pay direct debits from some types of account.

4. Your instructions to the bank and signature

- I instruct and authorise you to pay direct debits from my account at the request of HSF health plan.
- I confirm that the amounts to be debited are variable and may be debited on various dates.
- I understand that HSF health plan may change the amounts and dates only after giving me prior notice.
- PLEASE CANCEL ALL PREVIOUS STANDING ORDER INSTRUCTIONS IN FAVOUR OF HSF HEALTH PLAN.
- I shall duly notify the Bank in writing if I wish to cancel this instruction. I shall also so notify HSF of such cancellation.
- I understand that if any direct debit is paid which breaks the terms of this instruction, the Bank will make a refund.

Signature

Date

Payment by Credit and Debit cards to HSF health plan



- Please enter the card number clearly as incorrect numbers cause delays.
- If you wish to pay by LASER also complete the issue number.
- LASER cards also display your account number which is NOT required.

I authorise you, until further notice in writing, to charge my *VISA/MASTERCARD/LASER account the sum of

€ or such other amount, advised to me in advance for *six months'/one year's cover.

Please debit with this amount and the same amount *every six months/annually, (or such future amounts as apply to my cover) until cancelled. *DELETE AS APPROPRIATE

Name

(NAME AS IT APPEARS ON YOUR CREDIT/DEBIT CARD, BLOCK CAPITALS PLEASE)

Address

PLEASE ENTER THE CARD NUMBER CLEARLY AS INCORRECT NUMBERS CAUSE DELAYS

My Credit/Debit card number is

Valid from Date

 /

Expiry Date

 /

Issue Number (if applicable)

Signature

Date

Registration Number (for HSF use)

What to do next?

Once you have completed and signed this Application Form simply detach the slip below and keep for future reference, and return to HSF in the FREEPOST envelope provided.

And that's it.

PLEASE CUT OUT AND KEEP FOR FUTURE REFERENCE

The Direct Debit Guarantee

- This is a Guarantee provided by your own Bank as a Member of the Direct Debit Scheme, in which Banks and Originators of Direct Debits participate.
- If you authorise payment by Direct Debit, then
 - Your Direct Debit Originator will notify you in advance of the amounts to be debited to your account
 - Your Bank will accept and pay such debits, provided that your account has sufficient available funds
- If it is established that an unauthorised Direct Debit was charged to your account, you are guaranteed an immediate refund by your Bank of the amount so charged where you notify your Bank without undue delay on becoming aware of the unauthorised Direct Debit, and in any event no later than 13 months after the date of debiting of such Direct Debit to your account.
- You are entitled to request a refund of any Variable Direct Debit which exceeded the amount which you could reasonably have expected, subject to you so requesting your Bank within a period of 8 weeks from the date of debiting such Direct Debit to your account.
- You can instruct your Bank to refuse a Direct Debit payment by writing in good time to your Bank.
- You can cancel the Direct Debit Instruction by informing your Bank in good time.



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