Plaza 255
Blanchardstown Corporate Park 2
Ballycoolin Road
Dublin 15

Telephone: 01 899 1604.
Fax: 01 899 1707.
E-mail: customerservice@medicalaid.ie
Website: www.medicalaid.ie

(NB. Section A must also be completed when placing a Spouse/Partner/Child on cover in Section B.)

MEMBERSHIP APPLICATION FORM

Section A. I wish to join the Society:

Do you have current Health Insurance? YES ☐ NO ☐

If YES please enclose documentation showing the plan and level of cover for Inpatient and Outpatient care so as we can decide what "waiting periods" if any, will apply to any enhanced or additional cover benefits provided under the Society's policy.

If NO please provide a medical report from your GP outlining details of any current or underlying medical conditions.

Are you currently covered under your parents Garda Medical Aid plan? YES ☐ NO ☐

Garda No:_____ Station:_____ PPS No: _____ Email address: _____

Name: _____ D.O.B: _____ Contact No: _____

Address: _____

_____

Bank/Credit Union Account Details - Bank/Credit Union Name: _____

BIC: _____ IBAN: _____

NB: It is essential you supply Bank or Credit Union Account details in order to receive your benefit payments.

Section B. I wish to place my Spouse/Partner/Child on cover with the Society:

Does your Spouse/Partner/Child have current Health Insurance? YES ☐ NO ☐

If YES please enclose documentation showing the plan and level of cover for Inpatient and Outpatient care so as we can decide what "waiting periods" if any, will apply to any enhanced or additional cover benefits provided under the Society's policy.

If NO please provide a detailed medical report from your GP outlining details of any current or underlying medical conditions.

Name of Spouse/Partner: _____ D.O.B: _____ PPS No: _____

If Married - Date of Marriage: _____ Maiden Name:_____

Details of Children to be included in cover:

NAME	DATE OF BIRTH	PPS NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____

Initial Waiting Periods: An initial waiting period during which no benefit will be payable **may** apply to all new entrants who do **not** currently hold medical insurance as follows: New Entrant - up to 26 Weeks. Maternity & IVF Cover – 52 Weeks. New Born Babies – On cover provided they are registered and premium paid.

Pre Existing Condition Waiting Period: Where no current medical insurance cover exists and the signs or symptoms of any medical condition illness or ailment existed at anytime in the 6 months prior to applying for insurance a "waiting period" of 5 years **may** apply.

I certify that the information provided in support of this application is correct and I accept that I am bound by the Rules of the Society and I am entitled to the benefits as outlined in the Schedule of Benefits.

Signed:_____ Dated: _____

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STAMP

GARDA PAYROLL

DEDUCTION AUTHORISATION FORM

To: ACCOUNTANT, DEPARTMENT OF JUSTICE

I hereby agree to have my contributions to the above-named organisation deducted each week from my salary. Such contributions will be paid to the above organisation on my behalf. I also agree that deductions shall continue to be made unless otherwise notified by the above-named organisation **and that the rate of deductions may be changed from time to time by the above named organisation.** I recognise that, beyond making remittance to the organisation concerned equivalent to the amount deducted, the State accepts no further responsibility in the matter. I also recognise that the ultimate responsibility for ensuring that the deductions have in fact been made rest with me.

(Member to complete Shaded Areas only)

Signature: _____ BLOCKCAPITALS: _____

Date: _____ Employee No.: _____

[ ] (N = New)
(C = Change)
(S = Stop)

Organisation Code: [4][0][5][5]

Employee Registered No: [ ][ ][ ][ ][ ][ ]

Amount per pay period: [ ][ ][ ][ ][ ][ ]

Start Date: [ ][ ]-[ ][ ]-[ ][ ][ ][ ]

End Date: [ ][ ]-[ ][ ]-[ ][ ][ ][ ]

Reference(Account/Policy No.): [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Number of deductions: [ ][ ]
(possibly leave blank)

For Office Use

Enter for payday _____ Initials _____ Date _____

DED.GEN **Checked:** **Initials** _____ **Date** _____