ST. PAULS
GARDA MEDICAL AID SOCIETY

Widowed Form

Plaza 255, Blanchardstown Corporate Park 2, Ballycoolin Rd., Dublin 15.
Tel: 01 8991604 Fax: 01 8991707
E-mail:customerservice@medicalaid.ie Website: www.medicalaid.ie

Secretary
St Pauls Garda Medical Aid Society
Plaza 255
Blanchardstown Corporate Park 2,
Ballycoolin Rd.,
Dublin 15

OFFICE USE ONLY
Commencement _____
Cover _____
Over 18 Scheme _____
Total Sub _____
Reg No. _____
Receipt No. _____

My husband/wife _____ who was a member of St. Paul's Garda Medical Aid Society died on _____. I wish to make application to continue membership of the Society.

I give hereunder particulars of family

PLEASE COMPLETE IN BLOCK CAPITALS

Christian Name: _____ Surname: _____

Garda Reg. No: _____ Personnel No: _____

Address: _____

Date of Birth: _____ PPS No: _____Telephone No: _____

Details of Children to be included in cover:

Name	Date Of Birth
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Signature: ---------- **Date:** ----------

To: Paymaster General.
I hereby agree to have my contribution to St. Paul's Garda Medical Aid Society deducted from my Pension and that such contribution will be paid to St. Paul's Garda Medical Aid Society on my behalf at appropriate intervals. I also agree that deductions shall continue to be made unless otherwise notified by St. Paul's Garda Medical Aid Society. I recognise that, beyond making remittance to the organisation concerned equivalent to the amount deducted the State accepts no further responsibility in the matter.

Signature: ---------- Date: ----------

Pension Number: ---------- Garda Reg. No. ----------