St Paul's Garda Medical Aid Society
Suite 4, Plaza 255
Blanchardstown Corporate Park 2
Ballycoolin Road, Dublin 15
D15 NA7D

customerservice@medicalaid.ie
(01) 899 1604

Application form for Associate membership of St. Paul's Garda Medical Aid Society.

General Manager,
St Pauls Garda Medical Aid Society
Suite 4
Plaza 255
Blanchardstown Corporate Park 2,
Ballycoolin Rd.,
Dublin 15
D15 NA7D

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

I,_____(NAME) wish to apply for consideration to join St. Paul's Garda Medical Aid Society (the Society) as an associate member in accordance with the Rules of the Society. This application is based on my mandatory compliance with the Society Rules provisions as my application is founded on my family relationship through (NAME):_____ (*Reg. No./Membership No.): _____ who is/was my Spouse/Partner, Parent/Grandparent, Father-in Law/Mother-in Law *is/was a fully paid-up *member/associate member of the Society. ***Delete as applicable and initial deletion.**

I was previously named on a Society Medical Insurance Policy **Y/N**_____

I wish to make an application to obtain associate membership of the Society. I agree that if successful in this application I will be bound by the Rules of St. Paul's Garda Medical Aid Society and fully subject to its provisions in all aspects which I undertake to comply with. I understand the meaning of associate membership of the Society and acknowledge that I will not have a vote in any Society election or AGM, EGM or Special Meetings of members of the Society and will not be entitled to attend any of those said meetings.

I give hereunder particulars of family **PLEASE COMPLETE IN BLOCK CAPITALS**

First Name: _____ Surname: _____

Address: _____

E-Mail Address:_____ Date of Birth: _____ PPS No: _____Telephone No:_____

*Originating Member Garda Reg. No: _____Relationship_____ Pension No:_____

Proof of Address & Identification Documents Enclosed (Driving Licence/Passport) – please list

I consent to the Society communicating with the originating family member(s) to verify my family connection as part of this application.

Signed:_____ **Dated:** _____

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Details of Spouse/Partner and/or Children to be included in cover:

Name	Date Of Birth	Identification Documents
----------*Spouse/Partner	----------	----------
----------Child	----------	Birth Certificate --------
----------Child	----------	Birth Certificate --------
----------Child	----------	Birth Certificate --------
----------Child	----------	Birth Certificate --------
----------Child	----------	Birth Certificate --------

I certify that (NAME) _____ Reg No _____is my *spouse/partner and that the children listed above are my children or my *adopted/fostered children.

Signature: _____Date:_____
BLOCK CAPITALS

*** Delete as applicable and initial each deletion**

Signature:_____ Date:_____
BLOCK CAPITALS

OFFICE USE ONLY

Witness: _____ Date: _____
BLOCK CAPITALS

Witness Position in the Society_____