St. Pauls Garda Medical Aid Society

Plaza 255, Blanchardstown Corporate Park 2,
Ballycoolin Rd., Dublin 15.
Tel: 01 899 1604. Fax: 01 899 1707.
E-mail: customerservice@medicalaid.ie
Website: www.medicalaid.ie

M.A.3
Members Claim Form

OFFICE USE

Registered Number _____ Name _____

Address _____

_____ Station _____

If the claim or part of it is in respect of a child or children, the name and date of birth must be given.

Name: 1 _____ 2 _____ 3 _____ 4 _____ 5 _____

Date of Birth: _____ _____ _____ _____ _____

Does any part of the attached claim refer to expense incurred arising from;

Road Traffic Accident **YES** ❑ **NO** ❑

Injury on Duty **YES** ❑ **NO** ❑

Sporting Injury **YES** ❑ **NO** ❑

If YES, please indicate which sport (e.g.: GAA, Soccer, Rugby etc.) _____

PLEASE NOTE - EACH of these three questions MUST be answered before claim can be assessed for payment.

You are asked to retain your receipts and submit your claim on a three monthly basis.
In the case of financial hardship claims can be submitted more frequently.
Please group receipts together i.e. drugs, doctor, dental etc. and place in date order.

Electronic Payments into your Garda Credit Union/Bank Account *(not necessary if previously provided)*

If you sign up for this service, you will save money and bank charges and also having to visit your credit union or bank to lodge your cheque. Your claim will be paid at least 5 days earlier than payments by cheque. To sign up and gain these benefits please supply the following details:

Credit Union or Bank Name	*Credit Union or Bank Identifier Code (BIC)*	*Credit Union or International Bank Account Number (IBAN)*
_____	_____	_____

I certify that the information and documentation submitted in support of this claim are correct in every way.

Signed: _____ **Mobile No.** _____

Dated: _____ **Email:** _____

(In case we need to contact you re claims etc.)

OFFICE USE

DATE RECEIVED | **TOTAL PAYMENT** €