St. Pauls Garda Medical Aid Society

Plaza 255, Blanchardstown Corporate Park 2,
Ballycoolin Rd., Dublin 15, D15 NA7D.
Tel: 01 899 1604. Fax: 01 899 1707.
E-mail: customerservice@medicalaid.ie
Website: www.medicalaid.ie

# Members Claim Form

OFFICE USE

Registered Number_____ Name _____

Address_____

_____ Station _____

**Mobile No.:**_____ **Email:** _____

**(Please complete if your mobile number or email address has changed since your last claim)**

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

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

Date of Birth: _____ _____ _____ _____ _____

**PLEASE NOTE - Each of the four questions below MUST be answered before the claim can be assessed for payment - claim will be returned to you if not fully completed.**

**(Medical Expenses arising from an Occupational Injury while on Duty where a Compensation Claim is not being pursued against the State should be submitted to your local Superintendent's Office for payment.)**

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

| | | | |
|---|---|---|---|
| **Road Traffic Accident** | **YES** ❑ | **NO** ❑ | **Date if known:**_____ |
| **Injury on Duty** | **YES** ❑ | **NO** ❑ | **Date if known:**_____ |
| **GAA Sporting Injury** | **YES** ❑ | **NO** ❑ | **Date if known:**_____ |
| **Injury in School or Place of Work** | **YES** ❑ | **NO** ❑ | **Date if known:**_____ |

You are asked to retain **original** receipts (photocopies not accepted) and ideally submit your claim on a three monthly basis. The receipts must provide the name, address and qualification of the Doctor/Dentist/Consultant etc. and include the patients name, address and details of the treatment provided. Claims for dental treatment must also include the dental form fully completed by the dentist indicating the precise treatment provided. Prescription benefit is payable only when the drug prescribed has a drugs code and this code is shown on the drugs receipt provided by the pharmacy.

**Under Data Protection legislation, staff are confined to providing details of or alterations to the policy or of medical claims with the policy holder only – partners and children can be provided with general information like benefits etc.**

*If you wish to alter bank account details for payment of claims - please send the signed request to us in writing*

**I certify that the information and documentation submitted in support of this claim is correct in all regards.**

**Signed:** _____ **Date:** _____

**(Do not write on or alter or amend in any way any detail provided on any receipt/invoice)**

**OFFICE USE**

**DATE RECEIVED** | **TOTAL PAYMENT** €