



Please return this form to:
24 Upper Ground, London, SE1 9PD
tel: 020 7202 1381

or:
Suite 1.22 111 Union Street,
Glasgow, G1 3TA
tel: 0141 248 2168

Claim Form

Thank you for notifying us of your claim. All claims should be made within 6 months.
PLEASE USE BLACK INK AND BLOCK CAPITAL LETTERS AND ENSURE YOU SIGN THE DECLARATION ON THIS FORM.

To be completed by the Contributor

A Surname
Forenames
Address
Postcode



Registration No Signature

Employer Date
(If contributions are deducted from pay/pension)

Payment of your claim will normally be made directly to your Bank/Building Society account.* Please give details:

Name of the account holder(s) Account Number
Sort Code

*It will be possible to request cheque payment by indicating this here

This section must be completed in full for all claims (except for dental / optical / chiropody and birth grant) and is also required for every continuing claim. Missing information may delay claim settlement.

B Please answer the following questions in full:

- 1. What diagnosis has been given as the reason for the admission to hospital or for the consultation or for treatment etc.?
2. When did symptoms of this condition/problem first begin?
3. When was the family doctor first consulted about them?
4. Was the illness connected in any way with a previous one? YES / NO
If yes, please state date of previous illness

Hospital and Hospice

C Patient - Surname Forenames
Date of Birth Contributor Spouse/Partner Child under 18

TO BE COMPLETED BY THE PATIENT OR GUARDIAN OF CHILD UNDER THE AGE OF 18:

*Please delete as necessary

* I the patient/guardian of the named above, was an in-patient at the Hospital/Hospice mentioned below and authorise an official from that establishment to confirm the dates of my/my child's admission and discharge and to indicate to the HSF health plan the nature of my/the patient's illness by using one of the following categories: General, Geriatric, Psychiatric, Accident, Birth Grant-Ante/Post, Birth Grant - Confinement.

Signature (Patient or Guardian) Date

Name of Hospital/Hospice

Address

Ward Hospital No. (if known)

Date of Admission Date of Discharge

PLEASE NOTE - HSF HEALTH PLAN WILL CONTACT THE HOSPITAL OR HOSPICE, YOU DO NOT HAVE TO. HOWEVER IF YOU HAVE AN ORIGINAL HOSPITAL DISCHARGE CERTIFICATE PLEASE ENCLOSE IT.

Day Case Surgery/Treatment

This benefit is **ONLY** for planned day case surgery/treatment, **NOT** for emergency admissions for one day nor for outpatient appointments.

D Patient Surname _____

Forenames _____

Date of Birth _____ Contributor Spouse/Partner Child under 18

Name of Hospital _____

Ward _____ Date of Stay _____

To be completed by the hospital

Signature of authorised hospital official confirming day stay & occupancy of a bed:

Designation of above official _____

Official Stamp of Hospital

Other Categories

E Receipts enclosed Totalling £ _____

In words _____

Full name(s) of person(s) to whom the receipt(s) refer(s):

The receipts must:

- a) be originals, not photocopies;
- b) include the practitioner's stamp/name and date of issue;
- c) include the patient's name;
- d) state the type of service and items provided;
- e) be for a service covered by the HSF categories only and not for any insurance premiums paid to cover that service;
- f) be for a service for which payment has been met by a person registered under HSF health plan.

For a birth or adoption grant claim, please enclose an original full Birth/Adoption Certificate which will be returned to you promptly by post

(if you require a Special/Recorded service please include a self addressed envelope with the correct postage and completed official delivery label).

Receipts will not be returned unless requested.

Should it be necessary for my claim to be verified, I authorise the HSF health plan to approach the relevant clinical practitioner and authorise that practitioner to supply information to enable my claim to be processed.

SIGNATURE OF CONTRIBUTOR _____

DATE _____

Please tick the appropriate box to indicate the nature of the claim(s).	HSF USE
1. BIRTH / ADOPTION GRANT <input type="checkbox"/>	
2. SPECIALIST/INVESTIGATIONS <input type="checkbox"/>	
3. DENTAL / OPTICAL <input type="checkbox"/>	
4. HOME HELP <input type="checkbox"/>	
5. PHYSIOTHERAPY <input type="checkbox"/>	
OSTEOPATHY <input type="checkbox"/>	
CHIROPRACTIC <input type="checkbox"/>	
ACUPUNCTURE <input type="checkbox"/>	
HOMOEOPATHY <input type="checkbox"/>	
CHIROPODY <input type="checkbox"/>	
There are special claim forms for:	
FRACTURE/ TEMPORARY DISABILITY <input type="checkbox"/> <i>(Scheme 300 and above only).</i>	
PERMANENT DISABILITY <input type="checkbox"/>	
<i>Please refer to brochure for details of injuries applicable and tick box to request form. Claims should be made within 6 months.</i>	
Checklist	
1. Have you enclosed your receipts?	
2. Have you signed the form?	
3. Have you completed all of the relevant sections?	
4. Have you completed Pages 1 & 2?	
5. Have you supplied your bank account details?	