

# Application for membership of HSF health plan

Date Received – HSF use

Membership No. – HSF use

THIS PART MUST BE COMPLETED IN ALL CASES

I apply to join HSF health plan at the monthly rate indicated (PLEASE TICK)

<i>Scheme 950</i>	<i>Scheme 1450</i>	<i>Scheme 2050</i>	<i>Scheme 2650</i>	<i>Scheme 3600</i>	<i>Scheme 4550</i>	<i>Scheme 5500</i>
€9.50	€14.50	€20.50	€26.50	€36.00	€45.50	€55.00

Surname

Forename  Other Initials  Mr/Mrs/Miss Ms/Other

Address

Email  Tel: Work

Date of birth Contributor Day  Month  Year  Tel: Home

Date of birth Partner Day  Month  Year  Fax

Partner's Surname

Partner's Forename(s)

If already a member of HSF please state:	
Contribution	Membership No. (if known)

Children (*children must be under 18 years of age*)

Child's Surname	Child's Forename(s)	Sex	Date of Birth

HSF health plan uses the information given above for its own purposes. Any communications which you may receive are directly related to HSF services and those of the HSF Charitable Trust.

How did you obtain this brochure?

## Declaration

I declare that I and all persons to be included in this membership for whom benefit may be claimed are in good health and are not receiving or needing any form of medical treatment and have not had any medical conditions in the past for which treatment is not at present necessary. If this is not the case I have declared all relevant health information on the reverse of this form.

I understand that no claim will be accepted in respect of any conditions which existed or for which symptoms were present before membership or which began during the qualifying periods; nor for any developments of existing conditions; nor for any recurrence of conditions which have existed in the past; nor for any hereditary or congenital conditions which may already exist but which manifest symptoms only after membership commences, and that this application is accepted only on these terms. (Contributors changing schemes may be able to receive benefit at their former scheme rate for such conditions and will be advised if this is possible).

I agree to abide by HSF membership and benefits rules and conditions and the right of the Board of Directors to vary them and the range or rates of benefits or contributions if deemed necessary. I declare that all the information I have given on this application form is true to my best knowledge and belief and that if found to the contrary HSF shall be free to cancel the membership.

Signature  Date

**IMPORTANT: PLEASE COMPLETE THE MEDICAL INFORMATION SECTION ON REVERSE (PAGE 8)**

## Medical information


Your membership will be based on the information you supply on the whole of this application form. You must be satisfied that it is correct to the best of your knowledge and belief. To withhold or fail to disclose relevant facts (or to knowingly give false information) about the health and/or treatments of all persons to be covered in this membership could affect the benefits we are able to offer or could seriously influence your cover in the event of a claim. It could also lead to termination of membership or even be considered a criminal offence.

Please state any existing long term/chronic conditions even if at present under control.

PLEASE TICK BOX (if using 'Other' section, please state conditions in full and avoid abbreviations)

Name	Condition/Illness	Date symptoms began
	<input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> Raised blood pressure <input type="checkbox"/> Asthma <input type="checkbox"/> Arthritis <input type="checkbox"/> Other (PLEASE STATE) <hr/> <hr/>	

Please list other illnesses/operations, either current or in the past (state conditions in full and avoid abbreviations). Also list any medication being taken currently and state the condition/illness requiring the treatment.

Name	Condition/Illness	Date symptoms began
Signature 		Date

