

DEFENCE POLICE FEDERATION
HOSPITALISATION CLAIM FORM



Serving Members Name: _____

Division: _____ Rank: _____ No: _____

Date of Birth: _____ / _____ / _____

Address: _____

_____ Postcode: _____

Email Address: _____ Tel No: _____

Date of Accident / Illness: _____ / _____ / _____

Details of Accident / Illness: _____

Caused by: _____

Have you sustained injuries of this nature previously? YES* / NO*

Period of hospitalisation from: _____ / _____ / _____ to: _____ / _____ / _____

(Note: this must be immediately following accident or illness)

PLEASE ATTACH CONFIRMATION FROM THE HOSPITAL

Signed: _____ Date: _____

BANK DETAILS

When your claim has been approved we will make the payment to you directly to your Bank Account.

Please complete the following: -

Name and address of your Bank:

Branch Sort Code: ____/____/____

Account Number: _____

Account Name(s): _____

TO BE COMPLETED BY THE FEDERATION OFFICE:

I certify that the claimant is a member of the Scheme and that the claim details are correct.

Date of Joining Scheme:- ____/____/____

Signed: _____ Date: _____

Name: _____

DATA PROTECTION NOTICE

Philip Williams (G Ins) Management Ltd collects and uses your data in accordance with current data protection law (which includes, from 25 May 2018, the General Data Protection Regulation (Regulation (EU) 2016/679)) ("data protection law"). We maintain records in regard to policy claims on computer and/or paper files. Information will only be disclosed to third parties in whatever format is considered appropriate by us. By signing this form, you consent to Philip Williams (G Ins) Management Ltd using your data and the information you have provided to process the claim. Further information can be found in our Privacy Policy at <https://www.philipwilliams.co.uk>

Privacy Notice

Please Note: Our Privacy Notice can be viewed on our website at www.philipwilliams.co.uk
A hard copy can be provided upon request.