DEFENCE POLICE FEDERATION INSURANCE SCHEME – SICK PAY BENEFIT

1. The sick pay benefit is only payable to members who are notified by the Force that their pay is to be reduced because of absence due to sickness or injury.

2. If you have been notified that your pay is to be reduced please complete this form and return it to the Federation Office.

3. Payment of the benefit will be paid into your nominated bank account on a monthly basis.

4. Benefit ceases after the period determined by the Insurance policy or on earlier return to duty, or on earlier resignation or retirement from the Force.

5. The benefit will be 20% of your basic salary payable up to 26 weeks whilst you are on half pay. Benefits are free of tax under current law and legislation and Inland Revenue practice.

6. After the initial payment you will receive a supplementary claim form which must be returned to Philip Williams and Co. together with a copy of your next payslip.

7. The benefit may be terminated if you turn down any reasonable recuperative duties.

8. Your Statutory Sick Pay will cease at week 28 of sickness. It becomes your own responsibility to make a claim to the Department of Work and Pensions for Employment Support Allowance.

DEFENCE POLICE INSURANCE SCHEME SICK PAY BENEFIT CLAIM FORM

SURNAME: _____ FORENAME(S): _____

FORCE NUMBER: _____ RANK: _____

HOME ADDRESS: _____

_____

_____ POSTCODE: _____

EMAIL ADDRESS: _____ TEL NO: _____

I have been absent from duty since (date): _____ / _____ / _____

Suffering from (condition): _____

As a result I have been notified that my pay is to be reduced with effect from (date):

_____ / _____ / _____

I have returned to work on (date): _____ / _____ / _____

I attach a copy of the Force Notification regarding the Half Pay decision together with copies of my last monthly full pay-slip and a copy of the first monthly reduced pay-slip.

I claim benefit under the scheme and I will notify the underwriters should I return to work, retire or resign. If I am reinstated on full pay I will inform Philip Williams and Co immediately. If I receive full pay from the force for any period for which I have been paid benefit under the scheme by the insurers, I undertake to refund the benefit paid in full.

Signed: _____ Date: _____

FOR FEDERATION USE:

I CERTIFY THAT THE DETAILS STATED ABOVE ARE CORRECT AND THAT THE CLAIMANT IS A SUBSCRIBING MEMBER OF THE GROUP INSURANCE SCHEME.

Signed: _____ Date: _____

ON BEHALF OF THE TRUSTEES

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): _____

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.