MEDICAL SCHEME - WEST MERCIA

PLEASE COMPLETE ALL DETAILS: - (BLOCK CAPITALS, BLACK INK)

Officer □ Student Officer □ Transferee from another force □ Police Staff □

Mr □ Mrs □ Miss □ Ms □ Other ----------

Surname..... First Name(s) …… Date Birth ……

Collar No..... Man/Employee No…… Date of Joining Force ……

Member of convalescent home scheme? Yes /No Email Address ……..

How did you hear about the Health Scheme?.....

Home Address .....

..... Post Code.....

Home Telephone No..... Mobile No ……..

DEPENDANTS TO BE COVERED: (spouse/partner, children under 21)

Full Names	Relationship to Subscriber	Date(s) of Birth
1.....	.....	...../...../.....
2.....	.....	...../...../.....
3.....	.....	...../...../.....
4.....	.....	...../...../.....
5.....	.....	...../...../.....

Does anyone mentioned on this form have a pre-existing condition - No □ Yes □

If Yes, please give details on a separate sheet.

The information you have entered on this form will be held by the Trustees of TriCare Health Fund on a computerised database. TriCare Health Fund is registered under the Data Protection Act

MEMBERS DECLARATION

I apply to join the West Mercia Federation Health Fund. I confirm that the details on this form are true and correct to the best of my knowledge and belief. I agree to abide by the rules of the discretionary health scheme. I wish to pay subscriptions by Direct Debit. (completed mandate attached)/I am a serving police officer and wish to pay by payroll.

Signed ..... Date .....

Tricare Health Fund Office ,
United House, Unit 1 de Salis Drive
Hampton Lovett, Droitwich, WR9 0QE

West Mercia