St. Pauls Garda Medical Aid Society

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M.A.3(H)
Hospital Claim Form

OFFICE USE

Registered Number _____ Name _____

Address _____

Name of Hospital _____ Semi Private/Public _____

Date of Admission _____ Date of Discharge _____

WHAT HOSPITAL ACCOMMODATION DID YOU REQUEST?

Public ❑ **Semi-Private** ❑ **Private** ❑

NOTE: The Society covers the cost of a semi-private room in full in all hospitals. If you request a private room you will be liable for the extra cost.

If the claim or part of it is in respect of a spouse/partner or child or children, the name and date of birth must be given.

Name: 1 _____ 2 _____ 3 _____ 4 _____ 5 _____

Date of Birth: _____ _____ _____ _____ _____

Does any part of this claim refer to expense incurred as a result of a **Road Traffic Accident, Injury on Duty, Sporting Injury or were you referred for a Consultation/Treatment by the Chief Medical Officer of the Force?**

Please tick **Yes** ❑ **No** ❑

If yes please indicate which part of claim so refers.

All above questions must be answered before claim can be assessed.

CERTIFICATE

I accept that payment of any benefit in respect of this claim is subject to strict compliance with the rules of the Society, that determination as to the validity of claims shall be at the discretion of the Committee in accordance with Rule 11.

I certify that the information and documentation submitted in support of this claim are correct in every way.

Signed: _____ Dated: _____

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DATE RECEIVED | | **TOTAL PAYMENT** | € |