St. Pauls Garda Medical Aid Society

Plaza 255, Blanchardstown Corporate Park 2,
Ballycoolin Rd., Dublin 15.
Tel: 01 899 1604. Fax: 01 899 1707.
E-mail: customerservice@medicalaid.ie
Website: www.medicalaid.ie

M.A.3
Members Claim Form

OFFICE USE

Registered Number _____ Name _____

Address _____

_____ Station _____

If the claim or part of it is in respect of a 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.

You are asked to retain your receipts and submit your claim on a three monthly basis.
In the case of financial hardship claims can be submitted more frequently.
Please group receipts together i.e. drugs, doctor, dental etc. and place in date order.

Electronic Payments into your Bank Account

If you sign up for this service, you will save money and avoid bank charges and also having to visit your bank to lodge your cheque. Your claim will be paid at least 5 days earlier than payments by cheque. To sign up and gain these benefits please supply the following details:

Bank Name	***Bank Sort Code***	***Your Bank Account Number***
_____	_____	_____

(not necessary if previously provided)

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

Signed: _____ Contact No. _____

Mobile Ideally **(In case we need to contact you re claims etc.)**

Dated: _____

OFFICE USE

DATE RECEIVED _____ **TOTAL PAYMENT** € _____