WEST MERCIA POLICE FEDERATION
HOSPITALISATION CLAIM FORM

Serving / Police Staff *
(*Delete as applicable)

Members Name: _____

Date of Birth: _____ / _____ / _____ Collar No: _____

Address: _____

_____ Postcode: _____

Email Address: _____ Tel No: _____

Date of Accident / Illness: _____ / _____ / _____

Details of Accident / Illness: _____

_____

_____

Caused by: _____

_____

_____

_____

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

Note: this must be immediately following accident or illness

Totaling: _____ nights **(maximum payable 7 nights)**

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

Member Declaration:

I declare that the above statements are true and complete and that I remained in a hospital bed in a ward or intensive care unit **between midnight and seven o'clock** for each night claimed.

I attach a copy of the hospital admission and discharge certificate.

Signed: _____ Date: _____

BANK DETAILS:

When your payment 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): _____

Please return the completed form to: -
West Mercia Police Federation, Federation Office, United House, 1 De Salis Drive, Hampton Lovett, Droitwich, Worcs. WR9 0QE

Trustee Declaration:

I certify that the details stated above are correct and that the claimant is a subscribing member of the **West Mercia Police Federation Insurance Scheme** and submit this claim on behalf of the Trustees.

Date of Joining Scheme: - _____/_____/_____

Signed: _____ Date: _____

Name: _____

DATA PROTECTION NOTICE

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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.