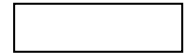


**MEDICAL SCHEME - WEST MERCIA**



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) ..... Birth Date .....

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**

