

MEDICAL SCHEME - GLOUCESTERSHIRE

Empty rectangular box

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

Officer Student Officer Transferee from another force Police Staff
PCSO Special Constable

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

1. I apply to join the Gloucestershire Police 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)

Signed Date

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



