MEDICAL SCHEME

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

Police Staff □ Police Civilian Support Officer (PCSO) □ Special Constable □

Mr □ Mrs □ Miss □ Ms □ Other ---------- Man/Employee No……

Surname..... First Name(s) …… Date Birth ……

Home Address .....

..... Post Code.....

Home Telephone No..... Mobile No ……..

Date of Joining Force ……. Email Address ……..

How did you hear about the Health Scheme?.....

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 Yorkshire 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

TriCare HEALTH FUND

DIRECT Debit

Instruction to your bank or building society to pay by Direct Debit

Please fill in the whole form using a ball point pen and send it to:

Tricare Health Fund
Unit 1
De Salis Drive
Hampton Lovett
Droitwich
WR9 0QE

Service user number

8	6	5	5	1	2

FOR TRICARE HEALTH FUND OFFICIAL USE ONLY
This is not part of the instruction to your bank or building society.

Health Scheme

Name(s) of account holder(s)

Bank/building society account number

Branch sort code

Name and full postal address of your bank or building society

To: The Manager — Bank/building society

Address

Postcode

Reference

Instruction to your bank or building society
Please pay Tricare Health Fund Direct Debits from the account detailed in this Instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this Instruction may remain with Tricare Health Fund and, if so, details will be passed electronically to my bank/building society.

Signature(s)

Date

Force Code **WY / GL / WM**

Banks and building societies may not accept Direct Debit Instructions for some types of account

DDI1

This guarantee should be detached and retained by the payer.

DIRECT Debit

The Direct Debit Guarantee

- This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits
- If there are any changes to the amount, date or frequency of your Direct Debit Tricare Health Fund will notify you 14 working days in advance of your account being debited or as otherwise agreed. If you request Tricare Health Fund to collect a payment, confirmation of the amount and date will be given to you at the time of the request.
- If an error is made in the payment of your Direct Debit, by Tricare Health Fund or your bank or building society, you are entitled to a full and immediate refund of the amount paid from your bank or building society
  - If you receive a refund you are not entitled to, you must pay it back when Tricare Health Fund asks you to
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.