MEDICAL SCHEME

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

Officer □ Student Officer □ Transferee from another force □ Police Staff □
Officer within 30 days of retirement □ Date of retirement …………….

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 …………………..

<u>DEPENDANTS TO BE COVERED</u>: (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

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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.

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

MEDICAL SCHEME

Signed .... Date ....

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